Miracle of Love Inc.
Clinical Quality Management Program
Quality Management Plan
2024-2030

Plan approved by Committee on April 2, 2024 | Board of Directors Approval April 16, 2024

Contents

Executive Summary

Miracle of Love Inc. (MOL) serves the Orlando Eligible Metropolitan Area (EMA) which covers Orange, Osceola, Lake, and Seminole Counties in Florida. MOL is a subrecipient (service provider) of multiple funding sources, including Ryan White HIV/AIDS Program (RWHAP) Part A and B, Housing Opportunities for Persons with AIDS (HOPWA), Targeted Outreach for Pregnant Women Act (TOPWA), as well as prevention programs which include HIV testing and education through the Florida Department of Health. The MOL Clinical Quality Management Plan ("Plan") is a written document that outlines the agency-wide Clinical Quality Management Program ("Program"). The purpose of the MOL Clinical Quality Management Program is:

1. Ensure clients receive services that meet or exceed established clinical guidelines and support service standards.
2. Ensure that services are inclusive, obtainable, and retain clients in HIV care.
3. Identify disparities in HIV care and assess options for reducing and/or eliminating them.
4. Continuously improve service process and procedures to reduce the disruption of client's daily lives, while achieving and maintaining viral suppression.
5. End the HIV Epidemic.

The Program utilizes data collection and analysis to select areas of improvement that can impact the quality of care for people living with HIV (PWH). The Plan is reviewed annually and updated throughout the year based on available data and analysis and utilizes evidence-based practices to find solutions. With guidance from the various funding source offices and annual program monitoring, the Program works to achieve goals and performance standards set forth.

In accordance with Health Resources and Services Administration (HRSA) Policy Clarification Notice (PCN) 15-02, the Program has been established to include a clinical quality management committee ("Committee"), a program director, dedicated resources, the ability to collect and analyze data, conduct quality improvement projects, and obtain input from PWH receiving services. As a subrecipient, the program and plan are focused on agency areas of improvement but works collaboratively with recipient offices and other subrecipients to target areas of improvement that are system wide.

The Committee and Program utilize bylaws to govern the procedures and processes in place (Miracle of Love Inc., 2024).

Authority and Accountability

Title XXVI of the Public Health Service Act and PCN15-02 (Health Resources and Services Administration, 2020) requires the establishment of a Clinical Quality Management Program to:

- Assess the extent to which HIV health services provided to clients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections; and
- Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to, and quality of HIV services.

Clinical Quality Management Committee

The Committee is a technical work group that has no legal, regulatory, or statutory authority, and exists at the discretion of MOL in accordance with the RWHAP Part A office. The Committee is the advisory body of the Program. The Committee is authorized to obtain data from all data collection sources within the purview of MOL services. The data is used to select quality improvement projects and set targets. If an improvement project results in a significant change, the Committee can propose, debate, and ultimately choose to approve or deny legislation that will foster the adoption of the change across all areas of impact. Resolutions can be presented as advice for the agency's leadership.

Clinical Quality Management Program

The Program is the "action" part of the improvement process. Quality Improvement activities set up by the Committee are carried out by the Program. The Program has one full-time employee and receives additional support and resources from all programs at the agency. The Program is responsible for ensuring the Committee's decisions are carried out and acts as the liaison between the agency and the Committee. The Program's authority is designated by the Executive Director.

Quality Manager

The role of the Quality Manager ("Program Manager") is to plan and organize Committee meetings and directly oversee implementation of projects, policies, and procedures. With a few exceptions, the Program Manager handles daily operations of the Program and may act without convening the Committee.

Resources

All resources necessary for the operation of the Committee and Program are appropriated when needed. Those resources include, but are not limited to, office supplies, staff, meeting space, access to clients, and access to data. The Program does not have a designated budget allocation and is not responsible for oversight of agency or program funds.

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.

Vision

To provide a continuum of care and support services that promote optimal health, decreases HIV transmission, reduces 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 needs.
- Maximizing the efficient use of resources to provide cost-effective services.

The Program will gather data and information about the services delivered by MOL and its staff, volunteers, and contractors and:

1. Will analyze the information and reports to measure outcomes and quality of services.
2. Report the analysis to identify areas requiring needed improvements.
3. Implement improvement activities to meet program goals.
4. Disseminate related information obtained from outside sources (i.e. Ryan White Planning Council, and related meetings and updates).

Objectives and Goals

The objectives of the Program at MOL are:

- Evaluate the effectiveness of programs and services.
- Review and analyze data to identify areas of improvement and plan activities.
- Monitor progress of quality improvement activities.
- Foster a culture of improvement across all parts of the agency.
- Recognize those that engage in improvement through various methods.

To establish annual goals for the Program, data is used to identify current performance levels and compare to accepted performance standards. Further review into demographics of recipients of the services and expectations of the service funders helps identify additional areas of improvement and goals. Goals are set based on current level and the incremental improvement to the accepted standard (i.e. current viral suppression is 82%. Standard is 88%. Goal: To increase viral suppression rates by 2% from 82% to 84%).

Quality Goals

The goals for the Quality Management Program through 2030 are:

- Achieve a ____ increase in housing stability and viral suppression for transgendered clients.
- Achieve 98% Quality Management Report engagement and completion.
- Increase interaction, testing, education, and linkage to care for African American adult females.
- Achieve a viral suppression rate of 98% for African American male clients that engage in male-to-male sexual contact (MMSC).

Our goals for this fiscal year are described in Table 1, Outcomes and Targets.

Quality Infrastructure

The Program is guided by the RWHAP Part A office, the Quality Management Technical Workgroup under the Central Florida HIV Planning Council, the MOL Board of Directors, and the Executive Director.

RWHAP Part A Office

The RWHAP Part A Office is responsible for coordinating healthcare services in the Orlando EMA. The RWHAP Part A Office guides and supports the Program through Technical Assistance (TA) and review of program compliance with PCN 15-02.

Quality Management Technical Workgroup (Central Florida HIV Planning Council)

The Quality Management Technical Workgroup serves as the Quality Management Committee for the Central Florida HIV Planning Council and serves both Ryan White Program Parts A and B. Oversight of the performance improvement plan and QI activities is conducted by this group.

Board of Directors and Executive Director

The MOL Board of Directors and the Executive Director guide, endorse, support, and champion the Program. They ensure that the Program remains in compliance with PCN 15-02, RWHAP Part A Office, and all other governing bodies responsible for determining Program responsibilities and authority. Through ongoing training and attendance at conferences and meetings, the Executive Director can stay apprised of the expectations of stakeholders and clients and provide guidance to the Program.

Clinical Quality Management Committee

As the advisory panel, the Committee reviews data, and aids in the selection of quality improvement projects and identifies areas for improvement.

Voting Members

The membership of the Committee reflects the diversity of clients served and services provided and includes:

- Representative of the Board of Directors
- Executive Director
- Quality Manager
- RWHAP Part A Representative
- Lake County Client Advisory Board Representative
- HOPWA Representative
- EHE Representative
- TOPWA Program Representative
- Prevention Program Representative
- Transgendered employee and/or client receiving Ryan White Services
- Client(s) receiving services at MOL (when available)

Non-Voting Members

In addition to the voting members, new members enter as Associate Members. Associate Members are appointed by the Executive Director after nomination by a member of the Committee or a program manager. As Associate Members, engagement in Committee business is encouraged, but participation in votes is forbidden. Associate Members shall be granted full membership and voting rights after attending more than 50% of the scheduled meetings, and a vote of the Committee approves the member.

Officers

Voting members will nominate and hold elections for the Committee officer roles of Chair, Vice Chair, Secretary, and Parliamentarian. Associate Members may be nominated for officer roles if they have been approved for voting rights in the following fiscal year and may participate in votes of officers. The responsibility for determining agenda topics and organization of the Committee shall be that of the Program Manager.

Role of the Committee

1. Develop and revise the Plan.
2. Monitor implementation of the Plan.
3. Oversee specific program and team projects.
4. Monitor and measure performance of service standards regarding clinical treatment, case management, and related services to determine effectiveness of the service standards.
5. Educate agency employees, volunteers, clients, and all other stakeholders on the tenants of the Program.
6. Authorize performance improvement initiatives and set forth quality expectations for ongoing monitoring.

Participation of Stakeholders

The involvement of stakeholders is critical to the success of the Program. To ensure stakeholders' ability to participate and engage, the Committee offers various methods to request to speak at a meeting, submit feedback, obtain Committee and Program documentation, and review current performance measures.

Any interested party may go to the Program public website at https://molcfl.org/ to view recorded meetings, review reports and plans, see current projects, and submit feedback or request to speak at a committee meeting. Material(s) that cannot be shared publicly are made available internally on the employee hub. Requests for copies of documents may be made on the website.

The Committee regularly invites members of the RWHAP Part A Office to participate and shares publicly the link for anyone to join a committee meeting virtually.

Evaluation

The Committee is responsible for evaluating the Program.

- 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.
- The Committee reviews the evaluation and recommends a plan for improvement to the Program Manager, and creates workgroups as needed.
- The Program Manager reports updates to the entire agency during staff meetings on behalf of the Committee.
- Annually the NQC OAT is completed with results incorporated in the revised Plan as necessary.

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.

Performance Measurement

Performance Measurement Tools

Selection of performance measures utilizes several tools, including the HIV Care Continuum, HRSA HAB Core Measures, the National HIV/AIDS Strategy Federal Implementation Plan, the Health and Human Services Ending the HIV Epidemic Initiative, and program monitoring.

HIV Care Continuum

This tool is used internally to measure success within MOL client populations. The HIV Care Continuum (HIV Care Continuum, 2022) consists of several steps required to achieve viral suppression. This model measures linkage to care, retention in care, and sustained viral suppression.

1. Diagnosed with HIV.
2. Linked to Care.
3. Received HIV Medical Care.
4. Retained in Care.
5. Achieved and Maintained Viral Suppression.

HRSA HAB Core Measures

HRSA HAB (HIV/AIDS Bureau Performance Measures, 2019) utilizes a standard formula for the measurement of six areas:

1. HIV Viral Load Suppression

2. Prescription of HIV Antiretroviral Therapy.
3. HIV Medical Visit Frequency.
4. Gap in HIV Medical Visits.
5. Pneumocystis jiroverci Pneumonia (PCP) Prophylaxis.
6. Annual Retention in Care.

National HIV/AIDS Stratetegy Federal Implementation Plan

The National HIV/AIDS Stratetegy Federal Implementation Plan (White House, The, 2021) defines four primary goals for HIV related services:

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.

Ending the HIV Epidemic in the U.S.

The EHE (Ending the HIV Epidemic, 2023) campaign is composed of four pillars, which can help achieve the goal of reducing new HIV infections by 90% by 2030.

1. Diagnose – Diagnose all people with HIV as early as possible.
2. Treat – Treat people with HIV rapidly and effectively to reach sustained viral suppression.
3. Prevent – Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
4. Respond – Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them.

Annual Performance Measures

The number of performance measures selected for each service category is based on utilization of said service.

Utilization Rate	Performance Measures
Service accessed by ≥ 50% of clients	Two Performance Measures
Service accessed by < 50% but ≥ 15% of clients	One Performance Measure

Gaps in service are reviewed annually to create quality improvement initiatives to eliminate, or at a minimum, reduce the gaps.

Data Sources

MOL case managers 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 the RWHAP Part A Office and the Committee. Employee satisfaction surveys are distributed by the Committee in collaboration with Human Resources.

To the extent possible, data for the performance measures are extracted from Provide Enterprise, CAREWare, Labcorp Link, ClientTrack, client satisfaction surveys, and employee satisfaction surveys. Obtaining reports and compiling them in a presentable format is the responsibility of the Program

Manager. Reports are presented to the entire body of staff during all 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.

Data Analysis

The Committee uses the Root Cause Analysis 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

Data shall be stratified by gender, age, SES, risk factor, geography, etc. to identify health disparities. This data is made available to all interested parties.

Performance Measures

Table 1 Outcomes and Targets provides a guide for selected performance measures, current measurements, and targets, intended target for current monitoring year. Table 2 Performance Measure Standards defines how the data is calculated.

Ryan White HIV/AIDS Program Part A

Intensive Medical Case Management

This service category is accessed by ≥50% of clients, resulting in the selection of two performance measures:

1. Viral Load Suppression
2. Annual Retention in Care

Referral for Health Care and Support Services (Referral Specialist)

This service category is accessed by ≥50% of clients, resulting in the selection of two performance measures:

1. Viral Load Suppression
2. Annual Retention in Care

Food Card

This service category is accessed by <50%, but ≥15% of clients, resulting in the selection of one performance measure:

1. Client Satisfaction

Excluded

Oral Health Care

The Program does not receive direct funding for this service category—clients are referred to directly funded oral health providers.

Ryan White HIV/AIDS Program Part B

Early Intervention Services

This service category performance measure is selected based on expected deliverables and includes one performance measure:

1. Linked to Ambulatory Outpatient Medical Care (AOMC)

Housing Opportunity for People with HIV/AIDS (HOPWA)

1. Housing Stability for clients receiving Permanent Housing Placement assistance.

HIV Prevention and Education Services

1. Client Satisfaction

Targeted Outreach for Pregnant Women Act (TOPWA)

1. Client Satisfaction

Agency Level Performance Measures

Inclusive of all programs and services, there are two selected agency level performance measures:

1. Client Satisfaction
2. Employee Satisfaction

Table 1: Outcomes and Targets

Area of Measurement: Service Category	Tool/Method for Measurement: Indicators	Target	2021	2022	2023	2024
Intensive Medical Case Management	Viral Suppression Annual Retention in Care	**88%** **65%**	86% 63%	80% 61%	82% 65%	+2 +1
Referral for Health Care and Support Services	Viral Suppression Annual Retention in Care	**94%** **67%**	87% 65%	80% 60%	85% 64%	+5 +3
Food Card	Client Satisfaction	**90%**	--	--	97%	-7
Early Intervention Services	Linked to Medical Care (AOMC)	**90%**	--	--	--	Base
HOPWA PHP	Housing Stability	**Base**	--	--	--	Base
HIV Prevention/Education	Client Satisfaction	**95%**	--	--	--	Base
TOPWA	Client Satisfaction	**95%**	--	--	--	Base
Agency – Client	Client Satisfaction	**95%**	96%	96%	92%	+3
Agency – Employee	Employee Satisfaction	**85%**	--	82%	77%	+8

Table 2: Performance Measure Standards

Performance Measure	Formulary
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.
Linked to Medical Care (AOMC)	Percentage of patients, regardless of age, with a diagnosis of HIV who attended an Ambulatory Outpatient Medical Care appointments within 30 days of the referral to EIS.
Housing Stability	Percentage of clients, regardless of age, with a diagnosis of HIV that received PHP financial assistance that remain housed in the same residence for at least six (6) months.
Client Satisfaction	Using a Likert scale with five levels from Very Dissatisfied to Extremely Satisfied. Client ratings are scored up to four (4) with Very Dissatisfied being a zero (0) and Extremely Satisfied being a four (4).
Employee Satisfaction	Using a Likert scale with five options. Employee ratings are scored up to four (4) with the highest level of satisfaction being a four (4) and the lowest being a zero (0).

Table 3: Data Collection Method and Reporting Timeline

Data Source	Parties Responsible	Collection Method	Reporting Frequency
HRSA HAB Performance Measures	Quality Manager	Provide Enterprise	Quarterly
EIS Deliverable Performance Measure	EIS Case Manager, Program Manager, and Quality Manager	CAREWare and/or Provide Enterprise	Quarterly
Client Housing Follow Up	Housing Program Manager and Housing Case Manager	Provide Enterprise, client data collection.	Quarterly
Client Satisfaction Survey	RWHAP Part A Office Quality Manager	Survey (Online/Paper) Survey (Online)	Quarterly Quarterly
Employee Satisfaction Survey	Quality Manager	Survey (Online)	Biannually

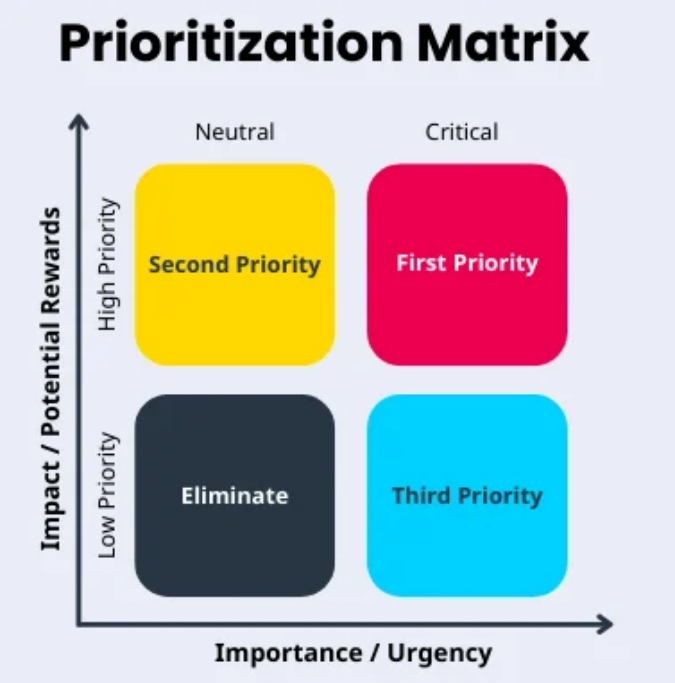
Quality Improvement

Quality Improvement (QI) projects and activities 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 and activity is implemented to address the service.

Project and Activities Selection and Prioritization

After review and analysis of available data, the Committee shall identify at least one opportunity for improvement. The Committee identifies the accountable participants and specifies the timeline for implementation of projects and activities. Selection of Quality Improvement (QI) projects and activities is done using the prioritization matrix (Figure 1). 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. Every attempt is made to ensure that the process is collaborative.

Figure 1. Prioritization Matrix



Methodology

Selected QI projects and activities use the Model for Improvement and Plan, Do, Study, Act (PDSA) as the primary methods. All projects are documented using the Model for Improvement worksheet/PDSA worksheet provided by the Ryan White HIV/AIDS Program Center for Quality Improvement and Innovation.

Model for Improvement

There are three steps in the Model for Improvement used to structure the QI project and activity:

1. What are we trying to accomplish?
    a. Create the aim statement.
    b. Formulate a hypothesis.
2. How will we know a change is an improvement?
    a. Determine the measures used to show the improvement.
3. What change can we make that will lead to an improvement?
    a. Group discussion.
    b. Flow Chart Analysis.
    c. Brainstorming.
    d. Observational Studies/Patient Flow.
    e. Activity Logs.

Plan, Do, Study, Act (PDSA)

Once the Model of Improvement has been utilized to structure the QI project and activity, the QI project will be completed using the Plan, Do, Study, Act (PDSA) methodology. This model is a widely used

framework for testing change on a small scale. Figure 2 illustrates the four steps required to assess a change.

Plan

Create a workable and realistic plan to address identified needs. QI plans consist of:

- Aim/Objective Statement (formulated using the Model of Improvement)
- Predictions/Hypothesis (formulated using the Model of Improvement)
- Plan for change/test/intervention
    - Who? (Target Population)
    - What? (Change/Test)
    - When? (Dates of Test)
    - Where? (Location)
    - How? (Description of Plan)
- Measures
- Plan for Data Collection
    - Who? (Will Collect)
    - What? (Measures)
    - When? (Time Period)
    - Where? (Location)
    - How? (Method)

Do

Deploy steps of the plan. Note when completed, observations, problems encountered, and special circumstances. Include names and details in the documentation.

Study

Follow up to ensure plan was implemented properly and outcomes are desirable. Summarize and analyze the data, both qualitative and quantitative. Include visuals, such as charts and graphs.

Act

Plan is fully implemented, and the cycle begins again. Document and summarize what was learned:

- Did you meet your aims and goals?
- Did you answer the questions you wanted to address?
- List major conclusions from this cycle.

Then define the next steps:

- Are you confident that you should expand the size/scope of the test or implement it?
- What changes are needed for the next cycle if a next cycle is needed?
- Do you need to revisit the hypothesis and recraft your aim statement?

Figure 2. Plan, Do, Study, Act (PDSA) Model

Sustaining Improvements

Regular feedback regarding QI projects and activities 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.

Work Plan

Just as it is important to select improvements based on data and utilize evidence-based practices to plan and test and improvement, a clear timeline must be established to ensure accountability. The timeline is used to determine milestones based on a projected period and is used for all the Program's projects and activities. The current work plan can be found in the appendices of this document.

Communication

Communication between the Committee/Program, agency leadership, program staff, the Board of Directors, and other stakeholders is key in having successful outcomes and ensuring ongoing improvements.

Agency Employees

To ensure that all employees of MOL have access to the information needed, the Committee/Program will maintain a repository of approved meeting agendas, approved meeting minutes, summaries of QI projects and activities, and the approved Plan in digital format on the employee hub. Additionally, an annual report will be provided to each employee by June 30 each year, that will identify the committee members, associate members, summary of the Plan, identify performance measures being monitored,

summary of current and/or planned QI projects and activities, results of previous QI projects and activities, and detail the annual work plan.

This annual report will be drafted by the Program Manager and made available through the employee hub. There will be a feedback window period from July 1 through July 31 annually, in which the employees may comment on the annual report. Submissions will be via an electronic form and can be submitted anonymously. All feedback is compiled and presented to the Committee at the first meeting scheduled after August 1 annually.

Employees that wish to provide input to the Committee may do so at any time of the year through multiple mediums. A form to request time to speak at a meeting is available on the employee hub. Employees may be invited to speak in person at a meeting or have their input entered into the record via a written submission or pre-recorded video. If the selected topic does not have a designated place on the current agenda, the employee comment period will be inserted prior to the *Old Business* portion of the agenda.

Employees are encouraged to suggest topics, provide input on QI projects and activities, present barriers to effective client services, or seek basic information from any member of the Committee. When possible, employees will be given an opportunity to provide feedback to the Committee/Program during all staff or department meetings after the topic has been presented on the meeting agenda.

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 Program Manager will be responsible for providing briefings to agency leadership at a time, place, and method agreed upon by leadership and the Program Manager. This may include in-person meetings, teleconferencing, or written reports either in hardcopy or electronic format.

During any interaction, leadership will have the opportunity to provide feedback, which will be communicated to the Committee and/or QI project and activities staff by the Program Manager. Leadership may also request to speak to the Committee via the internal method described in the prior section.

Board of Directors

The Executive Director (ED) is responsible for presenting and seeking board approval of the Plan annually.

A member of the Board of Directors will serve as a Committee Champion, which is a voting member on the Committee. This representative will present any communications on behalf of the Board of Directors to the Committee. The representative will also present any communication on behalf of the Committee to the Board of Directors.

If the representative is unable to attend, the responsibility for communicating with the Board of Directors and the Committee shall be transferred to the ED.

Ryan White HIV/AIDS Program Part A Office (Orange County Health Services)

The Program Manager, in partnership with the Executive Director, shall be responsible for communicating the required and requested information to the RWHAP Part A Office. In the absence of a

representative from RWHAP Part A Office at a committee meeting, the Program Manager is responsible for communicating to the Committee on behalf of the RWHAP Part A Office when necessary.

Other Stakeholders

All other interested parties can obtain public information regarding the Committee and the Program via the Program public facing website at https://molcfl.org/. Interested parties may also submit requests to speak at or submit statements to the Committee. A link to the Committee meetings is made public for those interested parties to attend any Committee meeting as they happen, virtually.

Committee Signatures

Quality Manager	4/17/24 Date
Committee Champion – Board of Directors	04/17/24 Date
Committee Champion – Executive Director	04/17/2024 Date
Committee Chair	4/17/2024 Date

Filed by the Secretary on the 18th of April, 2024.

Appendix A

Definitions

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

Appendix B

References

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Appendix C

Work Plan

FISCAL YEAR 2024														
Action Step	Measure of Compliance or Progress	Responsible Party(ies)	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
Goal: • Increase interaction, testing, education, and linkage to care for African American females, age 25+ by 3% by December 31, 2024.														
Obtain outreach numbers for this population in 2023	Submitted Measure	Bryan DuBac				X								
Review goal for adjustment		Committee				X								
Communication to team of goal.		Bryan DuBac			X	X	X	X	X	X	X	X	X	X
Collection and report of data		Bryan DuBac and Wyatt Haro			X	X	X	X	X	X	X	X	X	X
Report data quarterly to Committee		Bryan DuBac					X		X				X	

FISCAL YEAR 2024														
Action Step	Measure of Compliance or Progress	Responsible Party(ies)	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
Goal: • Achieve a 3% increase in housing stability and viral suppression for transgendered clients by December 31, 2025.														
Establish baseline	Data Collection	Julian Vega, Maylen Peguero, and Wyatt Haro												X
Create consent form for follow up		Julian Vega and Wyatt Haro				X								
Conduct follow up for clients meeting criteria at six (6) months post move-in		Julian Vega and HOPWA Team										X	X	X
Conduct follow up for clients meeting criteria at 12 months post move-in		Julian Vega and HOPWA Team												
Report collected date quarterly		Julian Vega												
Review goal for modification as necessary		Committee												

FISCAL YEAR 2024														
Action Step	Measure of Compliance or Progress	Responsible Party(ies)	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
Goal: • Achieve an increase of 3% viral suppression rate for African American male clients that engaged, or are engaging, in male-to-male sexual contact (MMSC) by December 31, 2024.														
Review available data collection method		Wyatt Haro			X									
Coordinate with Orange County Health Services for custom report		Wyatt Haro				X								
Communicate goal to all employees		Executive Team			X			X			X			X
Collect and report data quarterly to Committee		Wyatt Haro						X			X			X
Review goal for modification as necessary		Committee												

FISCAL YEAR 2024														
Action Step	Measure of Compliance or Progress	Responsible Party(ies)	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
Goal:														

Appendix D

Quality Improvement Project – Model for Improvement/PDSA

Received | Faxed | Submitted | Resolved
Other FILED

Date 22 MAR 2024

PDSA Worksheet

Organization/Group Name: MOL Food Card Survey Test Group

Wyatt Haro, MSW

Date: February 22, 2024 Initiated by: Wyatt Haro Cycle # 1

Purpose of this cycle:

PLAN the change, prediction(s) and data collection	
THE CHANGE: Clients are asked to complete a food card survey via electronic format.	
What are we testing?	The process for clients and case managers to collect survey data for food cards via electronic format.
On whom are we testing the change?	Clients receive food cards from three referral specialists located in a different county.
When are we testing?	February 22, 2024 – March 12, 2024
Where are we testing?	Case managers will be testing in their office locations.
PREDICTION(s):	
What do we expect to happen?	Clients may be resistant to technology or provide information for fear of losing the service, but the majority of clients feel empowered with the new process.
DATA:	
What data do we need to collect?	Case managers report for each cycle the client's responses to the survey, technical issues experienced, and how easy/hard it was for client to complete the survey.
Who will collect the data?	Each case manager will submit a QM Food Card Survey Test Experience report.
When will the data be collected?	Each cycle will be approximately four weeks. Data will be provided at meeting.
Where will data be collected?	At each location participating in the test.
DO: Carry out the change/test, collect data, and begin analysis	
What was tested?	Client accesses food card survey through QR scan code or via website link when receiving food card. Client, case manager, or third-party completes survey and finds the process easy, understandable, and not a burden.
What happened?	Approximately three-four clients experienced some technical issues with the QR code on their device. Clients reported the "future use" question was confusing.
Observations:	Most clients found the survey easy to complete and were more willing to provide honest feedback.
Problems:	Some wording of questions, questions included that were not necessary, and spam/human verification complications.
STUDY: Complete analysis of data. Summarize what was learned and compare to prediction (Use back of form to elaborate).	
ACT	
What adjustments to the change or method of test should we make before the next cycle? "Future Use" question was reworded and only asked if client has not used food cards before. Spam protection updated to Cloudflare Turnstile offering a more straightforward verification process. Second card questions were removed.	
Are we ready to implement the change we tested?	
What will the next test cycle be? (use back of form to elaborate) Continue the test with the above noted modifications and determine if the process is ready for small expansion to include providers issuing food cards in the field.	

(more detailed summary on the next page)

All three participants submitted a QM Food Card Survey Test Experience report prior to the end of the test cycle. All three reported that they had the opportunity to issue at least one food card during the test cycle. Two reported that at least one client was able to successfully complete the survey. Two reported that they were able to successfully complete at least one survey on behalf of a client. One reported that a friend/family member was able to successfully complete a survey on behalf of a client.

Case managers reported the following likes about this data collection method:
1. More data collected.
2. It's private/less paperwork.
3. Very detailed, precise, and concise to understand the data presented.

Case managers reported the following dislike about this data collection method:
1. Some clients are intimidated by tech and/or don't like change.
2. The confirmation of indicating if you are human (delays process of submitting data).

Experience submissions initially did not indicate any desired change of the process or questions. During the cycle meeting the case managers indicated some issues with a client not being able to access the survey via the QR code on their phone. Additionally, some clients were frustrated with the human verification/spam protection due to the overly complicated process. Although not a part of the survey process, a discussion arose about the education of the clients not receiving cards for months that they missed. This led to the discussion about removing the question from the survey if there was a second card number to enter.

At the end of the cycle meeting, changes to the survey were agreed upon and included the following:
1. Remove the question about future use from the survey if the client has received the food card in the past.
2. Reword the question about future use to specify "if eligible."
3. Set dynamic field to show future use question only if client has not received food card in the past or is unsure.
4. Spam protection/human verification (hCaptcha) was replaced with Cloudflare Turnstile which does an automatic human verification, and if it prompts for input to verify, it only offers a checkbox, rather than pictures or text.

Potential increase of participants for cycle 3 or 4 will be discussed at the conclusion of cycle 2. The group will reconvene on April 24, 2024 at 9:30 AM to close cycle 2.

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Thank you for participating in the Food Card Survey Test. Please answer the following questions honestly.

Name: Janice Romano Date: 3-8-2024

Test Dates: Start Date: 3-8-2024 Through Date: 3-12-2024

RECEIVED
MAR 13 2024
BY:

I have issued at least one food card during the current test period: ☒ Yes ☐ No
A client has successfully completed the survey: ☒ Yes ☐ No
I have successfully completed the survey on behalf of a client: ☐ Yes ☐ No
A friend or family member has successfully completed the survey for a client. ☐ Yes ☐ No

What do you like about this data collection method?
more data collected

What do you not like about this data collection method?
some clients are intimidated by tech and/or don't like change

Do you want to change any of the processes or questions of the survey?

Is this something you would feel comfortable participating in "buy-in" on this survey method? ☒ Yes ☐ No
Do you believe that your colleagues would accept this survey method? ☒ Yes ☐ No
Do you believe that the clients would accept this survey method? ☒ Yes ☐ No
Have you discussed the test with colleagues or clients? ☒ Yes ☐ No
If yes, what were the comments/thoughts given? (Do not identify names, but role (client/colleague)).
client was comfortable with the survey

If you would like to provide additional comments or thoughts, please submit an additional document in Word Format.

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Thank you for participating in the Food Card Survey Test. Please answer the following questions honestly.

Name: Ivette M. Laracuente Date: 3/13/2024

Test Dates: Start Date: 2/22/24 Through Date: _____

I have issued at least one food card during the current test period: ☑ Yes ☐ No
A client has successfully completed the survey: ☑ Yes ☐ No
I have successfully completed the survey on behalf of a client: ☑ Yes ☐ No
A friend or family member has successfully completed the survey for a client. ☐ Yes ☑ No

RECEIVED
MAR 13 2024
BY: ....

What do you like about this data collection method?

Its private/ less paperwork

What do you not like about this data collection method?

Do you want to change any of the processes or questions of the survey?

NO

Is this something you would feel comfortable participating in "buy-in" on this survey method? ☑ Yes ☐ No
Do you believe that your colleagues would accept this survey method? ☑ Yes ☐ No
Do you believe that the clients would accept this survey method? ☑ Yes ☐ No
Have you discussed the test with colleagues or clients? ☑ Yes ☐ No
If yes, what were the comments/thoughts given? (Do not identify names, but role (client/colleague)).

If you would like to provide additional comments or thoughts, please submit an additional document in Word Format.

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Thank you for participating in the Food Card Survey Test. Please answer the following questions honestly.

Name: Jose A. Vazquez Ortiz Date: 03/13/2024

Test Dates: Start Date: 02/22/2024 Through Date: 03/12/2024

RECEIVED
MAR 13 2024
BY: ...

I have issued at least one food card during the current test period: ■ Yes ☐ No
A client has successfully completed the survey: ■ Yes ☐ No
I have successfully completed the survey on behalf of a client: ■ Yes ☐ No
A friend or family member has successfully completed the survey for a client. ■ Yes ☐ No

What do you like about this data collection method?
Very detailed, precise and concise to understand the data presented.

What do you not like about this data collection method?
The confirnation of indicating if you are a human (delays process of submitting data).

Do you want to change any of the processes or questions of the survey?
Update food card rights and responsibilities
Update confirmation indicating if you are a human
Removing question regarding if client has a second food card

Is this something you would feel comfortable participating in "buy-in" on this survey method? ■ Yes ☐ No
Do you believe that your colleagues would accept this survey method? ■ Yes ☐ No
Do you believe that the clients would accept this survey method? ■ Yes ☐ No
Have you discussed the test with colleagues or clients? ■ Yes ☐ No

If yes, what were the comments/thoughts given? (Do not identify names, but role (client/colleague)).
Client's were amused, impressed on how technology has advanced to integrate the data collection very easily yet comfortable to understand.

If you would like to provide additional comments or thoughts, please submit an additional document in Word Format.

PDSA Worksheet

Organization/Group Name: MOL Food Card Survey Test Group

Date: March 13, 2024_____ Initiated by: __Wyatt Haro____ Cycle # __2_____

Purpose of this cycle:

PLAN the change, prediction(s) and data collection	
THE CHANGE: Clients are asked to complete a food card survey via electronic format.	
What are we testing?	The process for clients and case managers to collect survey data for food cards via electronic format.
On whom are we testing the change?	Clients receive food cards from three referral specialists located in a different county.
When are we testing?	March 13, 2024 through April 23, 2024
Where are we testing?	Case managers will be testing in their office locations.
PREDICTION(s):	
What do we expect to happen?	Clients may be resistant to technology or provide information for fear of losing the service, but the majority of clients feel empowered with the new process.
DATA:	
What data do we need to collect?	Case managers report for each cycle the client's responses to the survey, technical issues experienced, and how easy/hard it was for client to complete the survey.
Who will collect the data?	Each case manager will submit a QM Food Card Survey Test Experience report.
When will the data be collected?	Each cycle will be approximately four weeks. Data will be provided at meeting.
Where will data be collected?	At each location participating in the test.
DO: Carry out the change/test, collect data, and begin analysis	
What was tested?	Submission of food card survey via electronic means (i.e. mobile device through QR scan and/or link).
What happened?	With corrections in place from Cycle 1, only two technical issues were reported during this cycle, including the bubble selectors not showing on the screen, and one mobile device that was unable to access the survey via the QR code. It was also reported that client(s) indicated that the same questions each month were annoying.
Observations:	Clients appear to be receptive to the data collection method. Further testing is necessary to determine feasibility in the field.
Problems:	Not available in all languages and no back up option. Technical issues including unable to see entire survey on screen and not able to access for a single mobile device.
STUDY: Complete analysis of data. Summarize what was learned and compare to prediction (Use back of form to elaborate).	
ACT	
What adjustments to the change or method of test should we make before the next cycle? Create a back-up or alternative option for clients to access the survey through paper for the case manager to enter later.	
Are we ready to implement the change we tested? Not at this time. In field testing is necessary before a full rollout.	
What will the next test cycle be? (use back of form to elaborate) Continue with the three Referral Specialists in Lake, Orange, and Seminole counties. Seek approval to expand testing to include a case manager from Ryan White ICM team and one from EHE team to conduct in field testing.	

PDSA Worksheet

Organization/Group Name: MOL Food Card Survey Test Group

Date: April 24, 2024_____ Initiated by: __Wyatt Haro____ Cycle # __3_____

Purpose of this cycle:

PLAN the change, prediction(s) and data collection	
THE CHANGE: Clients are asked to complete a food card survey via electronic format.	
What are we testing?	The process for clients and case managers to collect survey data for food cards via electronic format.
On whom are we testing the change?	Clients receive food cards from three referral specialists located in a different county.
When are we testing?	April 24, 2024 through May 31, 2024
Where are we testing?	Case managers will be testing in their office locations.
PREDICTION(s):	
What do we expect to happen?	Frustration with the repetitiveness of the survey and not being available in a language other than English.
DATA:	
What data do we need to collect?	Case managers report for each cycle the client's responses to the survey, technical issues experienced, and how easy/hard it was for client to complete the survey.
Who will collect the data?	Each case manager will submit a QM Food Card Survey Test Experience report.
When will the data be collected?	Each cycle will be approximately four weeks. Data will be provided at meeting.
Where will data be collected?	At each location participating in the test.
DO: Carry out the change/test, collect data, and begin analysis	
What was tested?	Ongoing testing of technical and real-world applications to collect survey data for food cards.
What happened?	Reports of a couple of technical issues. Similar concerns raised in Cycle 2 were raised in this cycle, including repetitiveness and lack of offering in other languages.
Observations:	Most participants are satisfied with the process and have been accepting of the data collection method.
Problems:	No major problems reported this cycle.
STUDY: Complete analysis of data. Summarize what was learned and compare to prediction (Use back of form to elaborate).	
ACT	
What adjustments to the change or method of test should we make before the next cycle? Begin testing the ability for case managers in the field to use system and data collection technique.	
Are we ready to implement the change we tested? No. In-field testing must occur.	
What will the next test cycle be? (use back of form to elaborate) Testing will continue with three (3) referral specialists. Next cycle will include one (1) intensive case manager from Ryan White and one (1) EHE enhanced case manager to incorporate in-field testing.	

Cycle 3

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Thank you for participating in the Food Card Survey Test. Please answer the following questions honestly.

Name: Ivette M. Laraqueute Date: 5/23/2024

Test Dates: Start Date: 4/23/2024 Through Date: 5/29/2024

I have issued at least one food card during the current test period:	☑ Yes ☐ No
A client has successfully completed the survey:	☑ Yes ☐ No
I have successfully completed the survey on behalf of a client:	☑ Yes ☐ No
A friend or family member has successfully completed the survey for a client.	☐ Yes ☑ No

What do you like about this data collection method?

You get the truth. (cuts answers)

What do you not like about this data collection method?

N/A

Do you want to change any of the processes or questions of the survey?

the question about how much they receive? Let it is irrelevant - you know what the answer will be

Is this something you would feel comfortable participating in "buy-in" on this survey method?	☑ Yes ☐ No
Do you believe that your colleagues would accept this survey method?	☑ Yes ☐ No
Do you believe that the clients would accept this survey method?	☑ Yes ☐ No
Have you discussed the test with colleagues or clients?	☑ Yes ☐ No

If yes, what were the comments/thoughts given? (Do not identify names, but role (client/colleague)).

with clients they are excited about changes

If you would like to provide additional comments or thoughts, please submit an additional document in Word Format.

There should be an option to opt out of the survey.

Cycle 3

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Thank you for participating in the Food Card Survey Test. Please answer the following questions honestly.

Name: Janice Romano Date: 04/29/2024

Test Dates: Start Date: 4-24-2024 Through Date: 5-31-2024

I have issued at least one food card during the current test period:	■ Yes ☐ No
A client has successfully completed the survey:	■ Yes ☐ No
I have successfully completed the survey on behalf of a client:	■ Yes ☐ No
A friend or family member has successfully completed the survey for a client.	☐ Yes ☐ No

What do you like about this data collection method?

Simple to do
anonymous

What do you not like about this data collection method?

Do you want to change any of the processes or questions of the survey?

Is this something you would feel comfortable participating in "buy-in" on this survey method?	■ Yes ☐ No
Do you believe that your colleagues would accept this survey method?	■ Yes ☐ No
Do you believe that the clients would accept this survey method?	■ Yes ☐ No
Have you discussed the test with colleagues or clients?	■ Yes ☐ No

If yes, what were the comments/thoughts given? (Do not identify names, but role (client/colleague)).

Looking forward to trying it, and less papers to complete/turn in.

If you would like to provide additional comments or thoughts, please submit an additional document in Word Format.