



NATIONAL QUALITY CENTER

# Organizational Assessment Tool for Ryan White HIV/AIDS Program-funded Recipients

Updated June 2017



## **Introduction to Organizational Assessment Tool for Ryan White HIV/AIDS Program Part C and D Recipients**

### **Purpose of the Organizational Assessment:**

Sustained improvement activities require attention to the organizational clinical quality management (CQM) program, in which structures, processes, and functions support measurement and improvement activities. Development, implementation, and spread of sustainable quality improvement (QI) within HIV program requires an organizational commitment to quality management. Organizational infrastructure is fundamental to QI success, and involves a receptive organization, sustained leadership, staff training and support, time for teams to meet, and data systems for tracking outcomes. This structure supports quality initiatives that apply robust process improvement methodologies and tools, including: reliable measurement, root cause analysis, and finding solutions for the most important causes identified.

This assessment tool identifies all of the important elements associated with a sustainable CQM program. Scores from 0 to 5 are defined to identify activities achieved, as well as, gaps in the CQM program and to set program priorities for improvement. The scoring structure measures program performance in specific domains along the spectrum of improvement implementation. Scoring is designed so that all items in a score must be satisfied to reach any one score for a component. The organizational assessment been revised to take into account HAB's Policy Clarification Notice 15-02 and a level 3 in score will indicate meeting HIV/AIDS Bureau's basic expectations. Applied annually, this assessment tool will help a program evaluate its progress and guide the development of goals and objectives.

The organizational assessment is implemented in two ways: 1) by an external QI expert (i.e., QI consultant) or 2) as a self-evaluation. The results are ideally used to develop a workplan for each element with specific action steps and timelines guiding the planning process to focus on priorities, setting direction, and assuring that resources are allocated for the CQM program. Whether performed by a QI expert or applied as a self-evaluation, key leadership and staff should be involved in the assessment process to ensure that all key stakeholders have an opportunity to provide important information related to the scoring.

Results of the organizational assessment should be communicated to internal key stakeholders, leadership, and staff. Engagement of program leadership and staff is critical to ensure buy-in across the program, and essential for translating results into improvement practice.

**A. Quality Management**

**GOAL:** *To assess the HIV program-specific clinical quality management (CQM) infrastructure to support a systematic process with identified leadership, accountability and dedicated resources.*

Three components form the backbone of a strong sustainable CQM program: Leadership, Quality Planning, and a CQM Committee.

**Leadership**

Senior leadership personnel are defined by each organization since titles and roles vary among organizations. CQM programs should include a clinical leader (medical director, senior nurse) and an administrative leader (program coordinator, clinic manager, administrative director). Larger programs may include additional leadership positions. There may be other informal leaders in the organization who support quality improvement activities, but they are not included in this section.

Leaders establish a unity of purpose and direction for the organization and work to engage all personnel, consumers, and external stakeholders in meeting organizational goals and objectives. This includes motivation that promotes shared responsibility and accountability with a focus on teamwork and individual performance. HIV program leaders should prioritize quality goals and improvement projects for the year, and establish accountability for performance at all organizational levels. The benefits of strong leadership include clear communication of goals and objectives, where evaluation, alignment, and implementation of activities are fully integrated.

Evidence of leadership support and engagement includes the establishment of clear goals and objectives, communication of program/organizational vision, creation of sustainable shared values, and the provision of resources for implementation.

**Quality Management Plan**

Quality improvement planning occurs with initial program implementation and annually thereafter. A written quality management plan documents programmatic structure and annual quality team goals. The quality plan should serve as a roadmap to guide improvement efforts, and include a corresponding workplan to track activities, monitor progress, and signify achievement of milestones.

**Clinical Quality Management Committee**

A CQM committee drives implementation of the quality plan and provides high-level comprehensive oversight of the CQM program. This involves reviewing performance measures, developing workplans, chartering project teams, and overseeing progress. Teams should be multidisciplinary and include a client when feasible. Consumer representation on the committee should be part of a formal engagement process where consumer feedback is solicited and integrated into the decision making process. The committee should have regularly scheduled meetings, meeting notes to be distributed throughout the HIV program and a committee chair or chairs.

**A.1. To what extent does senior leadership create an environment that supports a focus on improving the quality of HIV care?**

<b>Getting Started</b>	0	<ul style="list-style-type: none"> <li>× Senior leaders are not visibly engaged in the quality of care program.</li> </ul>
<b>Planning and initiation</b>	1	<p><u>Leaders are:</u></p> <ul style="list-style-type: none"> <li>× Minimally involved in improvement efforts, quality meetings, or supporting provision of resources for QI activities.</li> <li>× Primarily focused on external requirements and supporting compliance with regulations.</li> <li>× Inconsistent in use of data to identify opportunities for improvement.</li> </ul>
<b>Beginning Implementation</b>	2	<p><u>Leaders are:</u></p> <ul style="list-style-type: none"> <li>× Not engaged optimally.</li> <li>× Engaged in quality of care with focus on use of data to identify opportunities for improvement.</li> <li>× Somewhat involved in improvement efforts.</li> <li>× Somewhat involved in quality meetings.</li> <li>× Supporting some resources for QI activities.</li> </ul>
<b>Implementation</b>	3	<p><u>Leaders are:</u></p> <ul style="list-style-type: none"> <li>× Providing routine leadership to support the clinical quality management program.</li> <li>× Providing routine and consistent allocation of staff or staff time for QI.</li> <li>× Actively engaged in QI planning and evaluation.</li> <li>× Actively managing/leading quality meetings.</li> </ul>

		<ul style="list-style-type: none"> <li>× Clearly communicating quality goals and objectives to all staff.</li> <li>× Recognizing and supporting staff involved in QI.</li> <li>× Routinely reviewing performance measures and patient outcomes to inform program priorities and data use for improvement.</li> <li>× Attentive to national and/or local health care trends/priorities that pertain to the agencies.</li> </ul>
<b>Progress toward systematic approach to quality</b>	4	<p><u>Leaders are:</u></p> <ul style="list-style-type: none"> <li>× Supporting development of a culture of QI across the program, including provision of resources for staff participation in QI learning opportunities such as seminars, professional conferences, QI story boards for distribution.</li> <li>× Supporting prioritization of quality goals based on data, and critical areas of care are addressed in coordination with broader strategic goals for HIV care.</li> <li>× Promoting patient-centered care and consumer involvement through the CQM program.</li> <li>× Routinely engaged in QI planning and evaluation.</li> <li>× Routinely providing input and feedback to QI teams.</li> </ul>
<b>Full systematic approach to quality management in place</b>	5	<p><u>Leaders are:</u></p> <ul style="list-style-type: none"> <li>× Actively engaged in the implementation and shaping of a culture of QI across the program, including provision of resources for staff participation in QI learning opportunities such as seminars, professional conferences, QI story boards for distribution.</li> <li>× Encouraging open communication through routine team meetings and dedicated time for staff feedback.</li> <li>× Routinely, actively, and consistently engaged in QI planning and evaluation.</li> <li>× Routinely, actively, and consistently providing input and feedback to QI teams.</li> <li>× Encouraging staff innovation through QI awards or incentives.</li> <li>× Directly linking QI activities back to institutional strategic plans and initiatives.</li> </ul>
<b>A.2. To what extent does the HIV program have an effective clinical quality management committee to oversee, guide, assess, and improve the quality of HIV services?</b>		
<b>Getting Started</b>	0	<ul style="list-style-type: none"> <li>× A clinical quality management committee has not yet been developed or formalized, or is not currently meeting regularly to provide effective oversight for the CQM program.</li> </ul>
<b>Planning and initiation</b>	1	<p><u>The quality committee:</u></p> <ul style="list-style-type: none"> <li>× May review data triggered by an event or problem, or generated by donor or regulatory urging.</li> <li>× Is minimally integrating quality activities into other existing meetings.</li> </ul>
<b>Beginning Implementation</b>	2	<p><u>The quality committee:</u></p> <ul style="list-style-type: none"> <li>× Has plans to hold regular meetings, but meetings may not occur regularly and/or do not focus on performance data.</li> <li>× Has been formalized, representing most institutional disciplines.</li> <li>× Has identified roles and responsibilities for participating individuals.</li> </ul>
<b>Implementation</b>	3	<p><u>The quality committee:</u></p> <ul style="list-style-type: none"> <li>× Is formally established and led by a program director, quality coordinator, medical director, or senior clinician.</li> <li>× Has implemented a structured process to review data for improvement.</li> <li>× Has drafted a workplan/calendar but it is not actively used to guide timely progress.</li> <li>× Has defined roles and responsibilities as codified in the quality management plan.</li> <li>× Reviews performance data regularly, including staff and consumer satisfaction, if available.</li> <li>× Discusses QI progress and redirects teams as appropriate.</li> </ul>
<b>Progress toward systematic approach to quality</b>	4	<p><u>The quality committee:</u></p> <ul style="list-style-type: none"> <li>× Represents all key Ryan White HIV/AIDS Program funded disciplines.</li> <li>× Has established a performance review process to regularly evaluate clinical measures and respond to results as appropriate, including staff and consumer satisfaction.</li> <li>× Communicates with non-members through distribution/accessible posting of minutes, and discussion in regular staff meetings.</li> <li>× Actively utilizes an annual workplan/calendar to closely monitor progress of quality activities and team projects.</li> <li>× Provides progress reports to the organization-wide quality program, if appropriate.</li> </ul>

Full systematic approach to quality management in place	5	<p><u>The quality committee:</u></p> <ul style="list-style-type: none"> <li>× Is a formal entity led by a senior clinician or administrator and, where appropriate, is linked to organizational quality committees through common members.</li> <li>× Is responsive to changes in treatment guidelines and external/national priorities (HAB, CMS), which are considered in development of indicators and choosing improvement initiatives.</li> <li>× Has fully engaged senior leadership and they lead discussions during committee meetings.</li> <li>× Effectively communicates activities, annual goals performance results, and progress on improvement initiatives to all stakeholders, including staff, consumers, and board members.</li> </ul>
<b>A.3. To what degree does the HIV program have a written comprehensive quality plan that is actively utilized to oversee quality improvement activities?</b>		
Getting Started	0	<ul style="list-style-type: none"> <li>× A quality plan, including elements necessary to guide the administration of a CQM program, has not been developed.</li> </ul>
Planning and initiation	1	<p><u>The quality plan:</u></p> <ul style="list-style-type: none"> <li>× Is written with some of the essential components necessary to direct an effective CQM program (see level 3).</li> <li>× May be written for the parent organization or for the network, but plans specific to the HIV program or for the network have not yet been developed.</li> </ul>
Beginning Implementation	2	<p><u>The quality plan:</u></p> <ul style="list-style-type: none"> <li>× Is written for the HIV program, and contains some of the essential components (see level 3).</li> <li>× Is under review for approval (if required by organization) by senior leadership, and includes steps for implementation.</li> </ul>
Implementation	3	<p><u>The quality plan:</u></p> <ul style="list-style-type: none"> <li>× Reflects in an effective HIV-specific clinical quality management program with all of the essential QI components including: <ul style="list-style-type: none"> <li>• Quality statement</li> <li>• Quality infrastructure definition and roles</li> <li>• Performance measures</li> <li>• Annual quality goals based on the prior year's results</li> <li>• Participation of stakeholders</li> <li>• Evaluation</li> <li>• Capacity building</li> <li>• Process to update the QM plan</li> <li>• Communication methodology to share information</li> <li>• CQM plan implementation timeline</li> </ul> </li> <li>× Is routinely communicated to program staff.</li> <li>× Includes an annual workplan/timeline outlining key activities of the CQM program, improvement initiatives, and accountable individuals/teams.</li> </ul>
Progress toward systematic approach to quality	4	<p><u>The quality plan:</u></p> <ul style="list-style-type: none"> <li>× Has been implemented and regularly used by the quality committee to direct the CQM program.</li> <li>× Includes annual goals identified on the basis of internal performance measures and external requirements through engagement of the quality committee and staff.</li> <li>× Includes a workplan, which is modified as needed and at least once/year to achieve annual goals.</li> <li>× Is routinely communicated to stakeholders including staff, consumers, board members, and the parent organizations, as appropriate.</li> <li>× Is evaluated annually by the CQM committee to ensure that the needs of all stakeholders are addressed and that changes in the healthcare and regulatory environment are assessed to ensure that the program meets the changing needs of the HIV patient.</li> </ul>
Full systematic approach to quality management in place	5	<p><u>The quality plan:</u></p> <ul style="list-style-type: none"> <li>× Is written, implemented, and regularly utilized by the quality committee to direct the CQM program, and includes all necessary components (see level 3).</li> </ul>

		<ul style="list-style-type: none"> <li>× Includes regularly updated annual goals that were identified by the quality committee using data on internal performance measures and external requirements through engagement of the quality committee and staff.</li> <li>× Includes a comprehensive workplan/timeline outlining key activities in place and is routinely and consistently used to track progress on performance measures and improvement initiatives, and modified as needed to achieve annual goals.</li> <li>× - <b>Not Applicable:</b> Is aligned with that of the parent organization and/or all network sites, as appropriate.</li> </ul>
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**Comments:**

New QM Plan for 2023-2024 is under committee review. Once committee has reviewed and approved any revisions, BOD will give final approval before implementation.

**B. Workforce Engagement in the HIV Clinical Quality Management Program**

***GOAL: To assess awareness, interest and engagement of staff in quality improvement activities.***

Staff engagement in quality activities at all organizational levels is central to QI success. This includes development and promotion of staff knowledge around organizational systems and processes to build sustainable clinical quality management programs. This may include internal management processes, operational barriers, patient interaction, and successful strategies to address barriers to QI implementation.

Ongoing training and retraining in QI methodology, and practical skills reinforce knowledge and the building of workforce expertise around QI. Training and retraining of staff can be accomplished through formal sessions provided internally by the organization or externally through legitimate training resources such as the National Quality Center (NQC). Training should be designed to build capacity and capability of the workforce based on regular assessment and reassessment of staff knowledge and skills. It can be conducted at different times and in different ways including a general overview during new staff orientations; integrated into regular staff meetings; can occur onsite or offsite; and may be sponsored by the organization or external credible organization. As staff progress along the continuum of QI sophistication, improvement is slowly integrated into clinic practice, enhancing staff engagement in the process. Immediate access to improvement data for example, empowers staff to focus on key areas of care and build consensus around QI activities to improve patient outcomes.

As QI becomes part of the institutional culture and team work progresses, staff embraces their respective roles and responsibilities, acquiring a sense of ownership and deeper involvement in improvement work.

**B.1. To what extent are physicians, other health professionals and staff routinely engaged in quality improvement activities and provided training to enhance knowledge, skills, and methodology needed to fully implement QI work on an ongoing basis?**

<b>Getting Started</b>	0	<ul style="list-style-type: none"> <li>× No staff (clinical and non-clinical) are routinely engaged in QI activities nor provided training to enhance skills, knowledge, theory, or methodology, nor are they encouraged to identify opportunities for improvement or to develop effective solutions.</li> </ul>
<b>Planning and initiation</b>	1	<u>Engagement of core staff in QI (clinical and non-clinical):</u> <ul style="list-style-type: none"> <li>× Is under development and include some training in QI methods and provides opportunities to attend meetings where QI projects are discussed.</li> </ul>
<b>Beginning Implementation</b>	2	<u>Engagement of core staff in QI (clinical and non-clinical):</u> <ul style="list-style-type: none"> <li>× Is underway and some staff have been trained in QI methodology.</li> <li>× Includes QI meetings attended by some designated staff.</li> </ul>
<b>Implementation</b>	3	<u>Engagement of core staff in QI (clinical and non-clinical) includes:</u> <ul style="list-style-type: none"> <li>× Attendance in at least one training in QI methodology.</li> <li>× Staff members are generally aware of program QI activities (quality plan/priorities).</li> <li>× Involvement in QI projects, project selection, and participation in a CQM committee.</li> <li>× Discussion and review of QI projects during staff meetings.</li> <li>× Defined staff roles and responsibilities related to QI.</li> </ul>

		<ul style="list-style-type: none"> <li>× Physicians and staff are aware of the quality plan and priorities for improvement.</li> </ul>
<b>Progress toward systematic approach to quality</b>	4	<p><u>Engagement of core staff in QI (clinical and non-clinical) includes:</u></p> <ul style="list-style-type: none"> <li>× Demonstrated evidence that staff members are engaged and encouraged to use QI skills to identify opportunities for improvements and to develop solutions.</li> <li>× A shared language regarding quality, which is evidenced in routine discussion.</li> <li>× Description in the annual quality plan, describing staff training, roles and responsibilities regarding staff involvement in QI activities.</li> <li>× A description of quality activities included in staff job descriptions, and staff engagement in quality activities is used in staff evaluation.</li> <li>× A formal process for recognizing staff performance internally and QI teams are provided opportunities to present successful projects to all staff and leadership.</li> </ul>
<b>Full systematic approach to quality management in place</b>	5	<p><u>Engagement of core staff in QI (clinical and non-clinical) includes:</u></p> <ul style="list-style-type: none"> <li>× Staff awareness of the importance of quality and continuous improvement, and their participation in identifying QI issues, developing strategies for improvement, and implementing strategies.</li> <li>× Regular and continuous QI education, and training in QI methodology.</li> <li>× Leadership who encourages all staff to make needed changes and improve systems for sustainable improvement, including the necessary data to support decisions.</li> <li>× Formal and informal discussions where teamwork is openly encouraged and leadership shapes teamwork behavior.</li> <li>× Routine communication about new developments in QI, including promotion of QI projects both internally (e.g., staff meetings) and externally (e.g., related conferences).</li> <li>× Opportunities for abstract development and submission to relevant professional conferences and authorship of related publications about development and implementation of institutional CQM programs.</li> </ul>
<p><b>Comments:</b>  <u>Implementation – 3:</u> All bodies staff meeting has not reconvened; however, QM is discuss in great detail during all department meetings.</p>		
<p><b>C. Measurement, Analysis, and Use of Data to Improve Program Performance</b>  <i>GOAL: To assess how the HIV program uses data and information to identify opportunities for improvement, develops measures to evaluate the success of change initiatives, to align initiatives, and to monitor program status; and to ensure that accurate, timely data and information are available to stakeholders throughout the organization to drive effective decisions.</i>  This section assesses how the program selects, gathers, analyzes, and uses data to improve performance. This includes how leaders conduct performance reviews to ensure that actions are taken, when appropriate, to achieve program goals.</p>		
<p><b>C.1. To what extent does the HIV program routinely measure performance and use data for improvement?</b></p>		
<b>Getting Started</b>	0	<ul style="list-style-type: none"> <li>× Performance measures have not been identified.</li> </ul>
<b>Planning and initiation</b>	1	<p><u>Performance measures:</u></p> <ul style="list-style-type: none"> <li>× Have been identified to evaluate some components of the program, but do not cover all significant aspects of service delivery.</li> <li>× Are defined and used by personnel at some but not all units or sites.</li> </ul> <p><u>Performance data:</u></p> <ul style="list-style-type: none"> <li>× Collection is planned pending initiation.</li> </ul>

<p><b>Beginning Implementation</b></p>	<p>2</p>	<p><u>Performance measures:</u>          × Are externally defined and used by personnel at all applicable sites.</p> <p><u>Performance data:</u>          × Validation, analysis, and interpretation of results on measures are in early stages of development and use.          × Results are occasionally shared with staff and patients.</p>
<p><b>Implementation</b></p>	<p>3</p>	<p><u>Performance measures:</u>          × Are externally defined or required (e.g., HAB, HIVQUAL), with the intent to meet external regulatory requirements and the needs of stakeholders, including patients.          × Are developed so that each RWHAP funded service category has at least one performance measure.          × For each highly utilized and highly prioritized RWHAP-funded service category, recipients have identified two performance measures and collect the corresponding data.          × Are defined and consistently used by personnel at all applicable sites.</p> <p><u>Performance data:</u>          × Are collected by staff with working knowledge of indicator definitions and their application.          × Are collected quarterly at a minimum.          × Validation, analysis, and interpretation of results on measures are sometimes conducted.          × Are tracked, analyzed and reviewed with the frequency required to identify areas in need of improvement. A structured review process is used regularly by the leadership to identify and prioritize improvement needs and initiate action plans to ensure that goals are achieved.          × Results and associated measures are routinely shared with staff and their input is elicited to make improvements.</p>
<p><b>Progress toward systematic approach to quality</b></p>	<p>4</p>	<p><u>Performance measures:</u>          × Are externally defined or required (e.g., HAB, HIVQUAL) and tied to annual organizational goals, with the intent to meet external regulatory requirements and the needs of stakeholders and patients, and goals of alignment with current evidence in the diagnosis and treatment of HIV.          × Reflect priorities of clinic staff and patients, in consideration of local issues.</p> <p><u>Performance data:</u>          × Results and associated measures are frequently shared with staff to elicit their input and engage them in improvement processes aligned with organizational goals.          × Validation, analysis, and interpretation of results on measures are routinely and consistently conducted.</p>
<p><b>Full systematic approach to quality management in place</b></p>	<p>5</p>	<p><u>Performance measures:</u>          × Are selected using organizational annual goals, with the intent to meet external regulatory requirements as well as the needs of stakeholders and patients, and goal of alignment with current evidence in the diagnosis and treatment of HIV.          × Are defined for each program component and actively used to drive improvement activities.          × Are evaluated regularly to ensure that the program is able to respond effectively and quickly to internal and external changes.</p> <p><u>Performance data:</u>          × Validation, analysis, and interpretation of results on measures are routinely and consistently conducted and are always considered when launching QI projects and other improvement activities.          × Are visible or easily accessible to ensure data reporting transparency throughout the agency.          × Are arrayed in formats that enable accurate interpretation, such as run charts and/or control charts.          × Results and associated measures are systematically shared with all stakeholders, including staff, patients, and boards to elicit their input and engage them in improvement processes aligned with organizational goals.</p>

**Comments:**

**D. Quality Improvement Initiatives**

**GOAL:** *To evaluate how the HIV program applies robust process improvement methodology to achieve program goals and maintain high levels of performance over long periods of time.*

This section examines how leadership and workforce use these methods and tools to conduct improvement initiatives with emphasis on identification of the exact causes of problems and designing effective solutions; determining program-specific best practices and sustaining improvement over long periods of time. In high reliability organizations robust process improvement methodology is routinely utilized for all identified problems and improvement opportunities to assure consistency in approach by all staff members.

Robust process improvement includes reliably measuring the magnitude of a problem, identifying the root causes of the problem and measuring the importance of each cause, finding solutions for the most important causes, proving the effectiveness of those solutions, and deploying programs to ensure sustained improvements over time.

**D.1. To what extent does the HIV program identify and conduct quality improvement initiatives using robust process improvement methodology to assure high levels of performance over long periods of time?**

<b>Getting Started</b>	0	<ul style="list-style-type: none"> <li>× Formal quality improvement projects have not yet been initiated in the CQM program.</li> </ul>
<b>Planning and initiation</b>	1	<p><u>QI initiatives:</u></p> <ul style="list-style-type: none"> <li>× No, or limited assessment of organizational performance or system level analysis of data performed, are not team-based, and do not use specific tools or methodology.</li> <li>× Reviews are primarily used for inspection.</li> </ul>
<b>Beginning Implementation</b>	2	<p><u>QI initiatives:</u></p> <ul style="list-style-type: none"> <li>× Are prioritized by the CQM committee based on program goals, objectives, and analysis of performance measurement data.</li> <li>× Involve team leaders and team members who are assigned by the CQM committee or other leadership.</li> <li>× Begin to use specific tools or methodology to understand causes and make effective changes.</li> </ul>
<b>Implementation</b>	3	<p><u>QI initiatives:</u></p> <ul style="list-style-type: none"> <li>× Are ongoing based on analysis of performance data and other program information, including external reviews and assessments.</li> <li>× Focus on processes of care, in which QI methodology is routinely utilized.</li> <li>× Are regularly documented and provided to CQM committee.</li> <li>× Involve staff on QI teams. Cross departmental/cross functional teams are developed depending on specific project needs.</li> </ul>
<b>Progress toward systematic approach to quality</b>	4	<p><u>QI initiatives:</u></p> <ul style="list-style-type: none"> <li>× Reflect input from staff through a transparent process.</li> <li>× Routinely and consistently reinforce and promote a culture of quality improvement throughout the program through shared accountability and responsibility of identified improvement priorities.</li> <li>× Are supported with appropriate resources to achieve effective and sustainable results.</li> <li>× Involve support of data collection with results routinely reported to QI project teams.</li> </ul>
<b>Full systematic approach to quality management in place</b>	5	<p><u>QI initiatives:</u></p> <ul style="list-style-type: none"> <li>× Are ongoing in every key service category.</li> <li>× Are guided by a team leader or sponsor, and include all relevant staff depending on specific project needs.</li> <li>× Correspond with a structured process for prioritization based on analysis of performance data and other factors.</li> <li><input type="checkbox"/> Are implemented by project teams. Further, clinicians and staff can identify an improvement opportunity at any point in time and suggest a QI team be initiated.</li> <li><input type="checkbox"/> Consistently and routinely utilize robust process improvement and multidisciplinary teams to identify actual causes of variation and apply effective sustainable solutions.</li> <li>× Are regularly communicated to the CQM committee, staff, and patients.</li> <li>× Routinely involve consumers on QI project teams.</li> <li><input type="checkbox"/> Are presented in storyboard context or other formats and reported to larger organization and/or placed in public areas for staff and patients (if relevant).</li> </ul>

		<ul style="list-style-type: none"> <li>× Involve recognition of successful teamwork by senior leadership.</li> <li>× Are supported by development of sustainability plans.</li> </ul>
<p><b>Comments:</b>  <b>Implementation 3:</b> Staff involvement has been limited in the QI committees. In order to gain more frontline participation in the QM committee, there was a discussion to start on-boarding associate members (<i>front-line team members</i>) in order to gain more participation from members outside of leadership.</p>		
<p><b>E. Consumer Involvement</b>  <b>GOAL:</b> <i>This section assesses the extent to which consumer involvement is formally integrated into the clinical quality management program.</i></p> <p>Consumer involvement encompasses the diversity of individuals using HIV programmatic services and can be achieved in multiple ways including solicitation of consumer perspectives through focus groups, key informant interviews, and satisfaction surveys; a formal consumer advisory board that is actively engaged in improvement work; consumers as members of program committees and boards; and conducting consumer needs assessments and including consumers in specific QI initiatives. Ideally, consumers have a venue to identify improvement concerns and are integrated into the process to find solutions and develop improvement strategies. Overall, consumers are considered valued members of the CQM program, where consumer perspectives are solicited, information is used for performance improvement, and feedback is provided to consumers.</p>		
<p><b>E.1. To what extent are consumers effectively engaged and involved in the HIV clinical quality management program?</b></p>		
<b>Getting Started</b>	0	<ul style="list-style-type: none"> <li>× There is currently no process to involve consumers in HIV CQM quality management program activities.</li> </ul>
<b>Planning and Initiation</b>	1	<p><u>Consumer involvement:</u></p> <ul style="list-style-type: none"> <li>× No formal process is in place for ongoing and systematic participation in CQM quality management program activities.</li> <li>× Is occasionally addressed by soliciting consumer feedback.</li> </ul>
<b>Beginning Implementation</b>	2	<p><u>Consumer involvement:</u></p> <ul style="list-style-type: none"> <li>× Is addressed by soliciting consumer feedback, with plans for the development of a formal process for ongoing and systematic participation in clinical quality management program activities.</li> </ul>
<b>Implementation</b>	3	<p><u>Consumer involvement:</u></p> <ul style="list-style-type: none"> <li>× Includes engagement with consumers to solicit perspectives and experiences related to quality of care.</li> <li>× Is formally part of HIV CQM program activities through a formal consumer advisory committee, satisfaction surveys, interviews, focus groups, or consumer training/skills building. However, the extent to which consumers participate in program activities is not documented or assessed.</li> </ul>
<b>Progress toward systematic approach to quality</b>	4	<p><u>Consumer involvement:</u></p> <ul style="list-style-type: none"> <li>× Is part of a formal process for consumers to participate in HIV CQR program activities, including a formal consumer advisory committee, surveys, interviews, focus groups, and/or consumer training/skills building.</li> <li>× In improvement activities includes three or more of the following: <ul style="list-style-type: none"> <li>– sharing performance data, QI activities and discussing quality during consumer advisory board meetings.</li> <li>– documenting in the HIV quality management plan.</li> <li>– membership on the internal quality management team or committee.</li> <li>– training on quality management principles and methodologies.</li> <li>– engagement to make recommendations based on performance data results.</li> <li>– increasing documentation of recommendations by consumers to implement QI projects.</li> </ul> </li> <li>× Information gathered through the above noted activities is documented and used to improve the quality of care.</li> </ul>

<p><b>Full systematic approach to quality management in place</b></p>	<p>5</p>	<p><u>Consumer involvement:</u></p> <ul style="list-style-type: none"> <li>× Contribution and its impact on quality is reviewed with consumers.</li> <li>× Is part of a formal, well-documented process for consumers to participate in HIV CQM program activities, including a consumer advisory committee with regular meetings, consumer surveys, interviews, focus groups, and consumer training/skills building.</li> <li>× In quality improvement activities includes four or more of the items bulleted in E1#4.</li> <li>× Information gathered through the above noted activities is documented, assessed, and used to drive QI projects and establish priorities for improvement.</li> <li>× Includes work with program staff to review changes made based on recommendations received with opportunities to offer refinements for improvements. Information is gathered in this process and used to improve the quality of care.</li> <li>× Involves at minimum, an annual review by the clinical quality management committee of successes and challenges of consumer involvement in CQM program activities to foster and enhance collaboration between consumers and providers engaged in quality improvement.</li> </ul>
<p><b>Comments:</b></p>		
<p><b>F. CQM Program Evaluation</b></p> <p><i><b>GOAL: To assess how the program evaluates the extent to which it is meeting the identified program goals related to quality improvement planning, priorities, and implementation.</b></i></p> <p>Quality program evaluation can occur at any point during the cycle of quality activities, but should occur annually at a minimum. The process of evaluation should be linked closely to the quality plan goals: to assess what worked and what did not, to determine ongoing improvement needs and to facilitate planning for the upcoming year. The evaluation examines the methodology, infrastructure and processes, and assesses whether or not these led to expected improvements and desired outcomes. At a minimum, the evaluation should assess access to data to drive improvements, success of QI project teams, and effectiveness of quality structure. Where appropriate, external evaluations and assessments should be utilized in partnership with the internal evaluation. The evaluation is most effectively performed by program leadership and the program’s clinical quality management committee, optimally with some degree of consumer involvement.</p>		
<p><b>F.1. Is a process in place to evaluate the HIV program’s infrastructure and activities, and processes and systems to ensure attainment of quality goals, objective, and outcomes?</b></p>		
<p><b>Getting Started</b></p>	<p>0</p>	<ul style="list-style-type: none"> <li>× No formal process is established to evaluate the CQR program.</li> </ul>
<p><b>Planning and Initiation</b></p>	<p>1</p>	<p><u>Quality program evaluation:</u></p> <ul style="list-style-type: none"> <li>× To assess program processes and systems is exclusively external.</li> </ul>
<p><b>Beginning Implementation</b></p>	<p>2</p>	<p><u>Quality program evaluation:</u></p> <ul style="list-style-type: none"> <li>× Is part of a formal process and is integrated into annual QM plan development.</li> </ul>
<p><b>Implementation</b></p>	<p>3</p>	<p><u>Quality program evaluation:</u></p> <ul style="list-style-type: none"> <li>× Occurs annually, conducted by the quality committee, and includes QM plan and workplan updates and revisions.</li> <li>× Involves annual (at minimum) revision of quality goals and objectives to reflect current improvement needs.</li> <li>× Results are used to plan for future quality efforts.</li> <li>× Includes a summary of improvements and performance measurement trends to document and assess the success of QI projects.</li> <li>× Results, noted above, are shared with consumers and other key stakeholders.</li> </ul>
<p><b>Progress toward systematic approach to quality</b></p>	<p>4</p>	<p><u>Quality program evaluation:</u></p> <ul style="list-style-type: none"> <li>× Findings are integrated into the annual QM plan and used to develop and revise program priorities.</li> <li>× Is reviewed during clinical quality management committee meetings to assess progress toward planning goals and objectives.</li> </ul>

		<ul style="list-style-type: none"> <li>× Includes review of performance data, which is used to inform decisions about potential changes to measures.</li> <li>× Is used to determine new performance measures based on new priorities.</li> <li><input type="checkbox"/> Includes analysis of QI interventions to inform changes in program policies and procedures to support sustainability.</li> </ul>
<b>Full systematic approach to quality management in place</b>	5	<p><u>Quality program evaluation:</u></p> <ul style="list-style-type: none"> <li>× Findings are integrated into routine program activities as part of a systematic process for assessing quality activities, outcomes and progress toward goals. Data and information are provided regularly to the CQM committee.</li> <li>× Is used by the CQM committee to regularly assess the success of QI project work, successful interventions, and other markers of improved care.</li> <li>× Includes data reflecting improvement initiatives, and is presented to ensure comprehensive analysis of all quality activities.</li> <li>× Uses a detailed assessment process. The results of this assessment are utilized to revise and update the annual QM plan, adjust the HIV program priorities, and identify gaps in the program.</li> <li>× Includes an analysis of progress towards goals and objectives and CQM program successes and accomplishments.</li> <li><input type="checkbox"/> Describes performance measurement trends, which are used to inform future improvement efforts.</li> <li><input type="checkbox"/> Communicates evidence that QI efforts informed through this process resulted in measurable change.</li> </ul>

Comments:

### **G. Achievement of Outcomes**

**GOAL:** *To assess HIV program capability for achieving excellent results and outcomes in areas that are central to providing high quality HIV care.*

In order to determine whether a program is achieving excellence in HIV care, a system for monitoring and assessing clinical outcomes should be in place. This system should include analysis of an appropriate set of measures; trending results over time; stratifying data by high-prevalence populations (see G2); and comparison of results to a larger aggregate data set (possible data sets for comparison include HIVQUAL, HAB, Regional Groups, RSR, VA, Kaiser, HIVRAD) used for programmatic target setting. A set of appropriate measures may be externally developed (i.e., HAB, HIVQUAL) and/or internally developed based on program goals. Viral suppression and retention in care are two essential measures of outcome that should be incorporated into the program's set of clinical measures.

#### **G.1. To what extent does the HIV program monitor patient outcomes and utilize data to improve patient care?**

<b>Getting Started</b>	0	<ul style="list-style-type: none"> <li>× No clinical performance results are routinely reviewed or used to guide improvement activities.</li> </ul>
<b>Planning &amp; Initiation</b>	1	<p><u>Data:</u></p> <ul style="list-style-type: none"> <li>× Some measures are routinely reviewed and used to guide improvement activities.</li> <li>× Trends for at least one measures is reported to determine if improvement occurs over time.</li> </ul>
<b>Beginning Implementation</b>	2	<p><u>Data:</u></p> <ul style="list-style-type: none"> <li>× Results for most measures are routinely reviewed and used to guide improvement activities.</li> <li>× Trends for some measures are reported.</li> </ul>
<b>Implementation</b>	3	<p><u>Data:</u></p> <ul style="list-style-type: none"> <li>× Results for all measures are routinely reviewed and used to guide improvement activities, including viral suppression and retention in care.</li> <li>× Trends for most measures are reported and some show improving trends over time.</li> <li>× Results are compared to a larger aggregate data set for at least 2 outcome measures: viral suppression and retention in care.</li> </ul>

		× Comparison to larger aggregate data set is used to set programmatic targets.
<b>Progress toward systematic approach to quality</b>	4	<u>Data:</u> × Comparison to larger aggregate data set is used to set programmatic targets, and targets are met for at least 50% of measures. × Results for viral suppression and retention in care scores are equal to or greater than the 75 <sup>th</sup> percentile of comparative data set.
<b>Full systematic approach to quality management in place</b>	5	<u>Data:</u> × Trends are reported for all measures and most show sustained improvement over time in areas of importance aligned with organizational goals. × Comparison to larger aggregate data set is used to set programmatic targets, and targets are met for at least 75% of measures. × Results for viral suppression and retention in care scores are above the 75 <sup>th</sup> percentile of comparative data set.

**G.2. To what extent does the HIV program measure disparities in care and patient outcomes, and use performance data to improve care to eliminate or mitigate discernible disparities?**

<b>Getting Started</b>	0	× No clinical performance results are routinely reviewed or used to address disparities.
<b>Planning &amp; Initiation</b>	1	<u>Performance measures/data:</u> × Are stratified for analysis of disparities by gender, age, SES, risk factor, geography, etc.
<b>Beginning Implementation</b>	2	<u>Performance measures/data:</u> × Are used to identify disparities. × Are used to plan improvement strategies to reduce disparities in HIV care.
<b>Implementation</b>	3	<u>Performance measures/data:</u> × Are used to develop and implement general improvement strategies.
<b>Progress toward systematic approach to quality</b>	4	<u>Performance measures/data:</u> × Are used to develop and implement general and targeted improvement strategies based on data analysis. × Demonstrate some evidence of improvement of outcomes for identified disparities.
<b>Full systematic approach to quality management in place</b>	5	<u>Performance measures/data:</u> × Demonstrate sustained evidence of improvement of outcomes for identified disparities.

Comments:

**H. HIV Care Continuum**

*GOAL: To assess how the HIV program generates and uses facility level cascades to identify opportunities for improvement and develop data-driven improvement plans, to align initiatives, and to ensure that accurate and timely information about the care engagement and viral suppression status of patients is available to all members of the facility so that they can effectively achieve both patient and public health outcomes.*

This section assesses how the program selects, gathers, analyzes and uses data based on the HIV care continuum to improve performance. This includes how care continuum data are collected and used by leaders, staff and the quality program to improve outcomes along the continuum throughout the entire healthcare agency and to achieve program goals.

**H.1. To what extent does the HIV program routinely generate and use facility level care continuum to drive improvement and address gaps in care?**

<b>Getting Started</b>	0	× <u>Facility</u> does not report required rates of retention, treatment and viral suppression.
<b>Planning &amp; Initiation</b>	1	<u>Facility:</u> × Reports required rates of treatment, retention, and viral suppression.

<b>Beginning Implementation</b>	2	<u>Facility:</u> × Can annually construct a continuum that reports rates of retention, prescribed ART, and viral suppression.
<b>Implementation</b>	3	<u>Facility:</u> × Can conduct an analysis, based on its facility level care continuum, to understand why patients do not meet expected outcomes and develop an intervention plan based on its analysis. × Facility leaders, CQM committee members, including providers and consumers, and facility staff use facility level care continuum to develop and implement a quality improvement plan. × Implements quality improvement plan, tracks the impact of interventions on facility level care continuum rates, and responds to the results of QI projects. × Involves community service agencies, including health homes, in process analysis and improvement plans to address linkage, engagement, re-engagement, and viral suppression. × Makes its care continuum visible to its internal stakeholders, and discusses it with its community advisory board.
<b>Progress toward systematic approach to quality</b>	4	<u>Facility:</u> × Can measure whether or not HIV infected patients are linked to medical care when they engage with any unit of the facility (including, but not limited to emergency room and supportive services) and can identify the status of every HIV infected patient ever seen at the facility. × Can stratify data to identify potential disparities in care provided to sub/state populations. × Identifies patients who are lost to follow up and reaches out to its local health department or other source to determine whether or not each patient has been engaged in care elsewhere.
<b>Full systematic approach to quality management in place</b>	5	<u>Facility:</u> <input type="checkbox"/> Produces, at least annually, a full care continuum that includes facility wide testing and linkage rates within the institution, including, but not limited to emergency departments, inpatient units and appropriate ambulatory care clinics. <input type="checkbox"/> Follows longitudinal cohorts of patients enrolled in care at the facility over a 24-month period to assess retention, treatment, and suppression.

Comments:

**I. Organizational Integration of HIV Supportive Service Programs and Clinical Activities**

*GOAL: Organizational quality management programs should actively integrate HIV programs and facilities that provide supportive services to patients with HIV; a successful quality program should demonstrate full integration by showing that CQM infrastructure and QI activities include all services that address the needs of HIV-infected patients.*

QM integration demonstrates a recognition of the important role of HIV supportive services that assist patients with entry and retention in HIV primary medical care, provide them with support to achieve viral suppression, and in fact include elements that support engagement at every stage in the care continuum.

Supportive services refer to all programs and services that support desired clinical healthcare outcomes. These may include but are not limited to care coordination programs, case management programs, food service programs, peer support and navigation programs, mental health programs, substance use programs, pharmaceutical programs, and community outreach programs, transportation programs, housing, or legal service programs.

**I.1. To what extent does the HIV program incorporate supportive services, and involve their staff, in its CQM program process and QI activities to improve patient outcomes along the care continuum?**

<b>Getting Started</b>	0	<u>Organization:</u> × Program has no history of involving supportive service programs in CQM efforts.
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<p><b>Planning &amp; Initiation</b></p>	<p>1</p>	<p><u>Organization:</u>  <input type="checkbox"/> Supportive services conduct QI activities and have their own closed CQM committee but these are separate from the HIV clinical CQM program.  <input checked="" type="checkbox"/> HIV QM plan does not reference supportive service activities.  <input checked="" type="checkbox"/> HIV CQM committee meetings occur without representation from supportive services.</p>
<p><b>Beginning Implementation</b></p>	<p>2</p>	<p><u>Organization:</u>  <input checked="" type="checkbox"/> Supportive service QI efforts are often separate, but they are reported to QM program at the HIV program's CQM committee as evidenced in meeting minutes.  <input checked="" type="checkbox"/> Has a communication structure in place to inform clinic and supportive services of QI activities. This may include dissemination of meeting minutes to all staff in supportive and clinical programs, newsletters, email blasts or meeting discussions documented in meeting minutes.  <input checked="" type="checkbox"/> Supportive services participate in clinical HIV CQM committee but in a limited manner (e.g., supportive service supervisors report on projects in supportive services, comment on clinical QI projects). However, they do not participate in integrated QI projects with both supportive services and clinical services working on the same QI team with the same QI goals.</p>
<p><b>Implementation</b></p>	<p>3</p>	<p><u>Organization:</u>  <input checked="" type="checkbox"/> Includes some supportive services in HIV CQM program. For instance, case management and care coordination services might be included in CQM committee meetings while food services might not.  <input checked="" type="checkbox"/> Data collection plans for supportive service programs are included as a component of the HIV CQM program's annual QM plan.  <input checked="" type="checkbox"/> CQM committee has reviewed QI activities conducted by supportive services and has a written plan to better integrate them with clinical efforts.</p>
<p><b>Progress toward systematic approach to quality</b></p>	<p>4</p>	<p><u>Organization:</u>  <input checked="" type="checkbox"/> The quality statement and goals included in the program's annual quality plan include all HIV services.  <input checked="" type="checkbox"/> Data collected in supportive service programs are reviewed and used in clinical QI efforts.  <input checked="" type="checkbox"/> Demonstrates through integrated quality meetings, and improvement projects as well as in the goals and activities delineated in the annual quality plan that the QM mission of clinical and supportive services are well-aligned.</p>
<p><b>Full systematic approach to quality management in place</b></p>	<p>5</p>	<p><u>Organization:</u>  <input checked="" type="checkbox"/> Has a fully integrated organizational QM plan that includes annual workplans for each supportive service program, as well as integrated goals that include plans to work towards goals with collaborative QI activities including both clinical and supportive services on QI teams.  <input checked="" type="checkbox"/> Representatives from all supportive service programs fully participate in the HIV CQM committee.  <input checked="" type="checkbox"/> Quality improvement projects routinely include and involve clinical and supportive service staff working on the QI team as evidenced in project documentation in storyboards or by other documentation that is shared with all stakeholders including consumers and staff of both supportive and clinical services.  <input checked="" type="checkbox"/> Demonstrates sharing of data, QI projects, and resources to improve outcomes as evidenced in the annual HIV QM plan, CQM program meetings, and documented QI activities.  <input checked="" type="checkbox"/> Performance measurement and QI data are communicated widely to staff and stakeholders throughout the program, transparently sharing progress on goals and improvement outcomes.  <input checked="" type="checkbox"/> Ensures that data collected in supportive service programs are reviewed and integrated with clinical program performance measurement as evidenced in the annual HIV QM plan.</p>
<p><b>Comments:</b></p>		

## Summary of Results

### **What are the major findings from the Organizational Assessment?**

Please number and link all findings with key recommendations and suggestions. Major findings should address all components especially those with – but not limited to - a score below 3.

Through our comprehensive organizational assessment, no significant findings or deficiencies were identified across any of the evaluated domains. Miracle of Love, Inc. has demonstrated a fully systematic and integrated approach to quality management. All components assessed are rated above a 4, indicating strong performance and consistent adherence to best practices. Our organization maintains a culture of continuous quality improvement, with well-established processes, staff engagement, data-driven decision-making, and client-centered care embedded across all programmatic and administrative functions.

### **What are the key recommendations and suggestions? What specific areas should be improved? What are specific improvement goals for the upcoming year?**

Please include associated timeframe for each recommendation and improvement goal. Recommendations and areas in need of improvement should address all components of importance.

#### **1. Enhance Consumer Engagement in Quality Activities**

##### **Area for Improvement:**

Maintaining consistent and meaningful client participation on the Quality Management Committee remains an area for growth.

##### **Improvement Goal:**

Identify, engage, and retain at least one active Ryan White consumer to serve on the QM Committee by the end of Q2 of the current fiscal year.

##### **Associated Timeframe:**

- **Q1 (Immediate–within 3 months):** Conduct outreach to current clients through case management, support groups, and peer networks to identify interested individuals.
- **Q2 (Within 6 months):** Provide orientation and training for the identified client representative(s), ensuring they are empowered to contribute meaningfully.
- **Ongoing:** Maintain quarterly check-ins to support client engagement and evaluate the effectiveness of their involvement.

#### **2. Improve Communication of QM Committee Activities to Broader Stakeholders**

##### **Area for Improvement:**

Communication regarding QM activities, outcomes, and ongoing improvement efforts is currently limited to committee members and key leadership, with less visibility to frontline staff and the broader organizational team.

##### **Improvement Goal:**

Develop and implement a formal communication strategy to share QM Committee updates and outcomes with all program staff, leadership, and interested stakeholders on a quarterly basis.

##### **Associated Timeframe:**

- **Q1 (Immediate–within 3 months):** Create a standardized communication template (e.g., QM Brief, newsletter, or infographic) summarizing key QM activities and findings.
- **Q2 (Within 6 months):** Launch the first quarterly QM communication update, distributed agency-wide via email, staff meetings, and posted in common areas.
- **Q3 and Q4:** Continue quarterly communications and incorporate feedback mechanisms to assess staff awareness and understanding of QM efforts.

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These recommendations will further advance Miracle of Love, Inc.'s commitment to a client-centered, data-informed, and transparent quality management program, enhancing both internal engagement and service outcomes.

**Comments By:** Angus Bradshaw, Jr.

**Date:** 04/30/2025

## Program Information

**HIV PROGRAM NAME:** Miracle of Love, Inc.

**Contact Person Name:** Angus Bradshaw

**Contact Email/Phone:** [ABradshaw@miracleofloveinc.org](mailto:ABradshaw@miracleofloveinc.org)

**Main Program Address:** 1301 W. Colonial Dr.

City: Orlando State: FL Zip Code: 32804

Fax: 407-843-1767

Please include the name and address of all of the program's clinics below, indicating the active HIV caseload for each. Select the check-box for each program to which this Organizational Assessment applies.

<input type="checkbox"/>	Executive Office	1380	Orlando	FL	32804
	<i>Site Name</i>	<i>HIV Caseload</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
<input type="checkbox"/>	MOL – Lake County	378	Mount Dora	FL	32757
	<i>Site Name</i>	<i>HIV Caseload</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
<input type="checkbox"/>	MOL – Osceola County	367	Kissimmee	FL	34741
	<i>Site Name</i>	<i>HIV Caseload</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
<input type="checkbox"/>	MOL – Seminole County Health	266	Orlando, Sanford	FL	32773
	<i>Department</i>				
<input type="checkbox"/>	<i>Site Name</i>	<i>HIV Caseload</i>	<i>City</i>	<i>State</i>	<i>Zip</i>

### Type of Facility

Select One

(for Part C and/or D funded):

- FQHC   × Community-based Clinic (non-FQHC)  
 University Hospital    Other Hospital    Other

### Funding Source(s):

Check all that apply

- × Part A   × Part B    Part C    Part D    AETC    Part F  
 Non-RWHAP State-Initiated Grants    Other HIV Grants:

### On-Site Services:

- Primary Care   × Case Management    Education/Training/Outreach  
× Peer Program    GYN Care    Dental Care    Mental  
Health    Pediatric Services    Substance Use    Ophthalmology  
 Methadone   × Testing/Counseling

Other: \_\_\_\_\_

### HIV Care Delivery:

- × Separate location and time    Separate only by time  
 Fully Integrated into general primary care

### Staffing:

- FT HIV Medical Director   × FT HIV Administrator

FT HIV Quality Manager If not FT, \_\_\_\_ % HIV Quality Manager

<b>Regional Group/Learning Network/Collaborative Involvement</b>	
Initiative Name	
Initiative Name	
Initiative Name	

Please note any events or other information that may have impacted service delivery, positively or negatively, since the last organizational assessment:

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**Survey Completed:** Name: Angus Bradshaw Jr. Date: 04/30/2025

**Assessment:**  baseline  annual If new, TA site since: /

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