2022-2023

Planning Council Meeting

Thursday, February 9th, 2023
4:00 pm - 6:00 pm

https://us02web.zoom.us/j/9178940335?pwd=R3VRY2t1TTN2SE52ZVcyTDhtbTEvdz09
Passcode: 20222023

Welcome, Introductions and Moment of Silence — 4:00 pm
Patrick Baum, PC Chair

Review and Approve January 12th Minutes — 4:05 pm
Patrick Baum, PC Chair

Committee Reports and Agency Updates — 4:10 pm
Executive Cte, NRAC, SPEC, MNC, Consumer Cte, Agency Reps

FY24 Funding Principles — 4:20 pm
Joey Carlesimo, NRAC Vice Chair

Service Standards Revisions & Vote — 4:40 pm
Service Standards Working Group

Knowledge Check: Breakout Rooms — 5:00 pm
PCS

Clinical Quality Management Intro & Updates — 5:20 pm
RWSD

Announcements, Evaluations and Wrap Up — 5:50 pm
Patrick Baum, PC Chair and PCS

Planning Council Meeting
Thursday, February 9, 2023
Zoom
4-6 PM

Summary of Attendance

Members Present
Justin Alves
Daniel Amato
Adam Barrett
Stephen Batchelder
Patrick Baum
Yvette Perron
Lamar Brown-Noguera
Henry Cabrera
Barry Callis
Joey Carlesimo
Stephen Corbett
Sandra Custodio
Beth Gavin
Robert Giannasca
Amanda Hart
Jerome Hazen
Darian Hendricks
Brian Holliday
Lorraine Jones
Allison Kirchgasser
Wendy LeBlanc
Jordan Lefebvre
Kathy Lituri
Margaret Lombe
Allan McClendon
Keith Nolen
Ericka Olivera
Arielle Pierre
Mahara Pinheiro
Manuel Pires
Serena Rajabiun
Luis Rosa
Darren Sack
Mairead Skehan Gillis
Michael Swaney
Bryan Thomas
Catherine Weerts
Karen White
Naika Williams
Kim Wilson

Members Excused
Larry Day
Melissa Hector
Jordan Lefebvre
Ethan Ouimet
Nate Ross
Tim Young

Members Absent
Damon Gaines

Staff
Claudia Cavanaugh
Vivian Dang
Clare Killian
Beth Williams

Guests

Topic A: Welcome and Introductions

Topic B: Review Meeting Minutes

Motion to Approve: --
Second: --
Result: The meeting minutes were approved with 87% approved and 13% abstained.

Topic C: Committee Reports and Agency Updates

Executive Committee

- No updates.

Consumer Committee

- Anti-Stigma campaign is in progress, PCS staff is working on proposal for EHE funding.
- Next education program will be before April Planning Council meeting (on Capenuva).

MNC

- Spoke this past Monday to go through the mid-year surveys and looking through results to understand everyone's goals in what to do to implement change.
- On active recruitment stage of Planning Council, asking members if there are any place we can table or appear to start recruitment.

NRAC

- Reviewed funding principals, resource allocation process, still conducting needs assessment.

SPEC

- Revised service standards. AAM is being edited.

BPHC

- Will be putting out RFP for EHE funding, will be open to all Suffolk County provider
- In process of updating provider manual to have for new Planning Council year
- Finalizing resource/consumer guide

MassHeath

- New Secretary of Health and Human Services, Kate Walsh, joining the team. Will keep current Medicaid director.
- Start redeterminations if people are eligible for MassHealth in April.

MA DPH

- Going to be assuming the Part D program. The program will move to office of HIV/AIDS July 1st because the director that oversaw that program retired.

NH DHHS

- Hired a new ADAP coordinator.

Mayor's Office

- No updates.

Topic D: FY24 Funding Principles

Council member explained what funding principals are, where do they come from, and who funds them.

Each Principle has equal importance, and in the context of Ryan White funding, a "provider" is defined as "a non-profit agency or public entity that is funded for one or more HIV service programs".

Principal 1: Services funded by Part A should provide for fair, equitable and just access for all *eligible* persons with HIV/AIDS throughout the EMA.

Principal 2: Services should meet essential needs of consumers as defined by credible and timely data/needs assessments.

Principal 3: Providers funded by Part A should seek input from and/or participation by consumers as critical in reaching their decisions.

Principal 4: Providers must be able to demonstrate relevant, established ties to the affected populations they serve. Such ties may be shown through staffing, language/cultural competency, community involvement, and site of services.

Principal 5: Providers should demonstrate a commitment to prevent and mitigate stigma to the extent possible within their environments.

Principal 6: Providers should be required to demonstrate optimal collaborations.

Principal 7: Providers should be encouraged to seek out and maximize the use of all funding sources, rather than solely relying on Part A.

Principal 8: Providers must demonstrate a willingness to provide services to all *eligible*, affected populations and an ability to provide appropriate services to the populations they target.

Principal 9: Providers should encourage and support self-advocacy among consumers.

Principal 10: Providers should design programs tailored to the needs of the population served; to this end, staffing qualifications should not be needlessly inflated to exclude persons from affected populations, who have the requisite skills, from being employed in service delivery.

- Motion for FY24 Funding Principals amending number 10 to include requisite skills and lived or living experiences: 86% approved, 3% opposed, 11% abstained.
- Will change and upload document

Principal 11: Funding decisions should be made in such a way as to encourage the development/ maintenance of high quality, user-friendly, innovative services.

Principal 12: To ensure continuity of services, there should be a preference for organizations that provide services within the priority areas and demonstrate linguistic/cultural competency and appropriateness.

Principal 13: Staff funded by Part A may not solicit or accept personal gifts, travel, meals, or entertainment with a value in excess of $50, from any pharmaceutical company or any person or entity that provides or is seeking to provide goods or services to Part A funded agencies, or that does business with, or is seeking to do business with, a Part A funded agency. Faculty, clinicians, or staff funded by Part A who are expected to participate in meetings of professional societies as part of their continuing professional education should be aware of the potential influence, both direct and indirect, of pharmaceutical companies on these meetings and should use discretion in evaluating whether and how to attend or participate in these educational events, lectures, legitimate conferences and meetings.

Topic E: Service Standards Revisions & Vote

Planning Council Member goes over timeline of Service Standard Revisions

December

- Service standards were presented to SPEC, working group created.

January
- Working group revied and provided edits to send to all of SPEC
- Open comment period for SPEC to review Standards
- RWSD reviewed edits and responded
- Working group reviewed RWSD edits

February
- Today, working group presents edits to Planning Council

Some edits made:
- Replacing "low-income" to income eligible so it is more inclusive and holds less stigma.
- Specify business days and do not include weekend days
- Use more respectful language, i.e.: "passed away" instead of "died"

Vote to approve the FY24 Service Standards as reviewed and approved by the Services, Priorities and Evaluations Committee and Ryan White Services Division.
- 91% approved the motion, 9% abstained.

Topic F: Knowledge Check: Breakout Rooms

Create a real-world example of how the Service Standards impact how agencies function.

Some member responses:
- Talked about not inflating job descriptions, incorporating lived experiences
- Using EFA funds specifically for EFA purposes, for example, if a client comes in an office and needs housing financial support, we'd directly refer them to agencies that specifically focus on that versus using that agency's EFA funds for it.
- A scenario on someone who is experiencing homelessness might be having a difficult time accessing medication and how having some service standards like timely intake or linkage to referrals might be helpful.

Topic G: Clinical Quality Mangement Intro & Updates

Senior Program Manager and Senior Program Coordinator from CQM Team discuss updates on the program.

Clinical Management Intro:
What is Clinical Quality Management?

Quality, focusing on four key points:
- Efficiency
  - Eliminate waste of time and effort
- Effectiveness
  - Accomplish the intended purpose
- Equity
  - Ensure that opportunities for health are accessible to all
- Satisfaction
  - As measured by the consumer

Quality is made of Quality Assurance, Quality Improvement, and Clinical Quality Management

Quality Assurance- A broad spectrum of activities aimed at ensuring compliance with minimum quality standards
Quality Improvement- A deliberate process to continuously improve efficiency, effectiveness, equity, and satisfaction in the current system
Clinical Quality Management- The coordination of activities aimed at improving patient care, health outcomes, and patient satisfaction among PLWH/A

Ryan White CQM Program has three major components: Infrastructure (CQM Plan, committee, staff, etc), Performance Measures (e2Boston, performance measure plan, data sharing, etc), and Quality Improvement (training and building capacity in EMA to do improvement work, and performances, making improvements, etc)

Update:

- Started the year off finalizing a CQM strategy for FY 2022-24.
- Goals and objectives:
    - The first is a non-clinical goal to promote and sustain a culture of continuous Quality Improvement throughout the EMA.
    - The second goal is to increase the viral suppression rate, especially given that it had dipped a little bit in FY 2021.
        - cannot improve the viral suppression rate without improving adherence to ART, increasing the percentage of clients linked to HIV care within 30 days of diagnosis, and addressing stigma against HIV and its syndemics.
- CQM is hiring another Program Coordinator, focusing in Quality Improvement, to fulfill full CQM Committee to implement plans, goals, and objectives.
- Part of CQM Plan is committing to support a CQM Committee that is representative of the Boston EMA population, that meets six time per fiscal year, and that advises on the development, annual revision, and implementation of the CQM Plan and corresponding activities.
    - To meet this objective, some of the action steps that we successfully completed in FY22 included:
        - Setting up an online hub for the Committee to access necessary materials – although we may need to try a different platform in the next year
        - Establishing and clearly communicating a set of activities for which the CQM Committee is responsible each year (i.e. an annual workplan)
        - And incorporating regular data sharing and discussion into every meeting

Challenges:

- Limited program capacity
- Far less focus on Quality Improvement work and capacity-building

Future Directions:

- Bring back focus on EMA-wide Quality Improvement with:
    - Quality improvement Learning Collaborative
    - Tiered QI Learning approach based on culture assessment results
    - Creation of a QI resource library
    - Hire a Senior QI Coordinator with strategic recruitment
    - Recorded QI training content from CQM.
- Escalate Collaborative
- Increase consumer involvement in EMA-wide QI discussion.

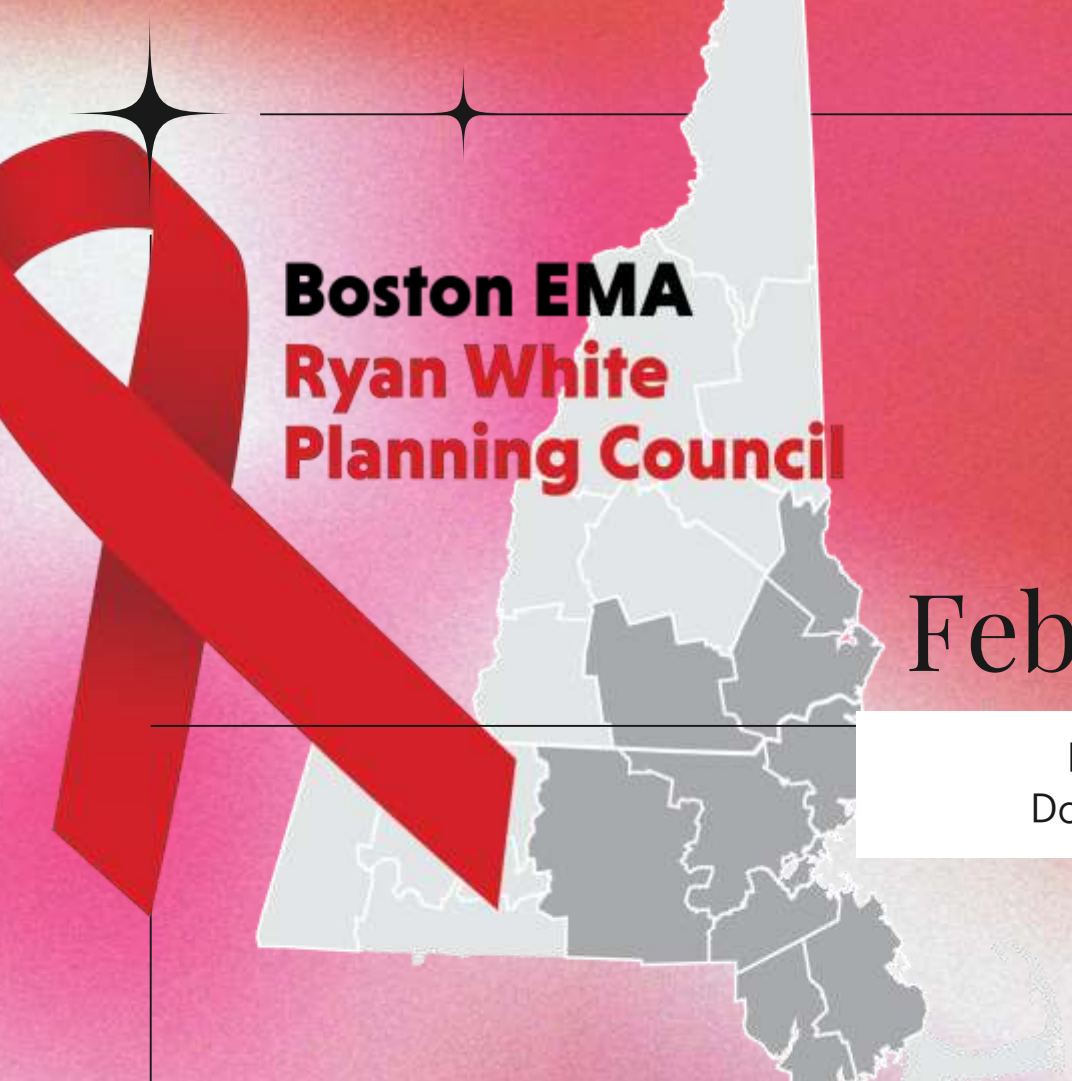
Topic H: Announcements, Evaluation & Adjourn

Announcements:

- Let planning council know about any potential recruitment events.
- There is a research participation opportunity at Northeastern, for any people living with HIV over the age of 50, being in a nursing home for 3+ months.

Meeting to Adjourn
Motion: Catherine Weerts
Second: Darren Sack
Result: The meeting was adjourned at 6:00pm

Boston EMA Ryan White Planning Council



February 2023

Patrick Baum, Chair
Darren Sack, Vice Chair

Moment of silence

At this moment, let's take a moment of silence in remembrance of those who came before us, those who are present, and those who will come after us.

HI! I'M VIVIAN

I am really looking forward to working with you all as a new Program Coordinator for the Ryan White HIV/AIDS Planning Council and to work alongside Clare and Claudia!

Attendance

When we call on you for attendance, say “here” or “present” and answer the question – **if you had to only eat one food for the rest of your life, what food would it be?**

AGENDA

01
Review & Approve January Minutes

02
Committee Reports & Agency Updates

03
FY24 Funding Principles

04
Service Standards Revision & Vote

05
Knowledge Check: Breakout Rooms

06
Clinical Quality Management Intro & Updates

01

Review & Approve January 12th Minutes

January 12th, 2023
First and Second Motion
Zoom Poll

02 Committee Reports & Agency Updates

Executive Committee
Patrick Baum

Consumer
Robert Giannasca

MNC
Michael Swaney

NRAC
Catherine Weerts

SPEC
Margaret Lombe

BPHC
Eileen Merisola

MassHealth
Alison Kirchgasser

MA DPH
Barry Callis

NH DHHS
Yvette Perron

Mayor's Office
Melissa Hector

03 FY24 Funding Principles

What are the funding principles?

» Overall directives guiding the work of NRAC in the creation of its funding recommendations to the Council.

Where do the funding principles come from?

» They have evolved over the past 20 years to reflect the Planning Council's values and guide its processes leading to the allocation of funds.

Who uses the funding principles?

» **NRAC** – To guide the funding scenarios for all funding recommendations NRAC presents to the Planning Council

» **BPHC** - Uses these principles when contracting funded services and monitoring agencies. It is embedded in the RFP document and the grantee ensures the agencies are following these principles.

Each Principle has equal importance, and in the context of Ryan White funding, a “provider” is defined as “a non-profit agency or public entity that is funded for one or more HIV service programs”.

1. Services funded by Part A should provide for fair, equitable and just access for all *eligible* persons with HIV/AIDS throughout the EMA.

2. Services should meet essential needs of consumers as defined by credible and timely data/needs assessments.

3. Providers funded by Part A should seek input from and/or participation by consumers as critical in reaching their decisions.

Each Principle has equal importance, and in the context of Ryan White funding, a “provider” is defined as “a non-profit agency or public entity that is funded for one or more HIV service programs”.

4

Providers must be able to demonstrate relevant, established ties to the affected populations they serve. Such ties may be shown through staffing, language/cultural competency, community involvement, and site of services.

5

Providers should demonstrate a commitment to prevent and mitigate stigma to the extent possible within their environments.

6

Providers should be required to demonstrate optimal collaborations.

Each Principle has equal importance, and in the context of Ryan White funding, a “provider” is defined as “a non-profit agency or public entity that is funded for one or more HIV service programs”.

7 Providers should be encouraged to seek out and maximize the use of all funding sources, rather than solely relying on Part A.

8 Providers must demonstrate a willingness to provide services to all *eligible*, affected populations and an ability to provide appropriate services to the populations they target.

9 Providers should encourage and support self-advocacy among consumers.

Each Principle has equal importance, and in the context of Ryan White funding, a “provider” is defined as “a non-profit agency or public entity that is funded for one or more HIV service programs”.

10 Providers should design programs tailored to the needs of the population served; to this end, staffing qualifications should not be needlessly inflated to exclude persons from affected populations, who have the requisite skills, from being employed in service delivery.

11 Funding decisions should be made in such a way as to encourage the development/ maintenance of high quality, user-friendly, innovative services.

12 To ensure continuity of services, there should be a preference for organizations that provide services within the priority areas and demonstrate linguistic/cultural competency and appropriateness.

Each Principle has equal importance, and in the context of Ryan White funding, a “provider” is defined as “a non-profit agency or public entity that is funded for one or more HIV service programs”.

13

Staff funded by Part A may not solicit or accept personal gifts, travel, meals, or entertainment with a value in excess of $50, from any pharmaceutical company or any person or entity that provides or is seeking to provide goods or services to Part A funded agencies, or that does business with, or is seeking to do business with, a Part A funded agency. Faculty, clinicians, or staff funded by Part A who are expected to participate in meetings of professional societies as part of their continuing professional education should be aware of the potential influence, both direct and indirect, of pharmaceutical companies on these meetings and should use discretion in evaluating whether and how to attend or participate in these educational events, lectures, legitimate conferences and meetings.

04 Service Standards Revisions & Vote

Claudia Cavanaugh, Beth Gavin and Kim Wilson

December

Service Standards were presented to SPEC, working group created

January

Working group reviewed and provided edits to send to all of SPEC

Open comment period for SPEC to review Standards

January

RWSD reviewed edits and responded

Working group reviewed RWSD edits

February

TODAY: Working group presents edits to Planning Council

Section 1: Universal Standards

Original Language	Edited Language	SPEC Rationale
Are accessible to all people with HIV in the designated 10 counties that constitute the Boston EMA;	Are accessible to all people living with HIV in the designated 10 counties that constitute the Boston EMA; **This edit has been corrected several times throughout the document	Add the word "living" into the phrase "people with HIV"

Section 3.4: Accessibility of Setting to Low-Income Individuals

Original Language	Edited Language	SPEC Rationale
Services delivered by provider are available in settings that are readily accessible to low-income individuals.	Services delivered by provider are available in settings that are readily accessible to income eligible individuals. **Replace "income eligible" for "low-income" in section heading and all other cases throughout the document	"Low-income" can be considered a disrespectful term. "Income eligible" is more inclusive and holds less stigma.

Section 1.0 : Eligibility, Insurance, & Recertification

Original Language	Edited Language (BPHC & SPEC)	SPEC Rationale
Ryan White legislation requires that individuals receiving services through Ryan White Part A funding must have a diagnosis of HIV, reside in the Boston EMA and be low-income	Ryan White legislation requires that individuals receiving services through Ryan White Part A funding must have a diagnosis of HIV, reside in the Boston EMA and be income eligible as detailed in this section.	Defining "income eligibility" is important in a paragraph that discusses subrecipient eligibility and the use of Ryan White funds

Section 2.1: Intake, Discharge, Transition & Case Closure

Original Language	Edited Language	SPEC Rationale
Standard: Within 14 days of initial contact with a client, the agency must perform an intake. **Measure:** Record of intake completed, including all required components, within 14 days of initial contact of client	**Standard:** Within 14 business days of initial contact with a client, the agency must perform an intake. **Measure:** Record of intake completed, including all required components, within 14 business days of initial contact of client	Specify these are business days, and do not include weekend days

Section 2.4: Discharging, Transferring or Case Closures

Original Language	Edited Language	SPEC Rationale
Standard: The agency must have policies and procedures in place to discharge, transition and/or close cases when the client: • Relocates out of the service area • Has no direct program contact in the past 6 months (becomes inactive) despite provider contact to engage in care. • No longer needs the service • Discontinues from the services • Is incarcerated for a year or longer • Exhibits threatening behavior • Has died Policies and procedures for discharge must include at least 3 attempts to contact the client before discharge.	**Standard:** The agency must have policies and procedures in place to discharge, transition and/or close cases when the client: • Relocates out of the service area • Has no direct program contact in the past 6 months (becomes inactive) despite provider contact to engage in care. • No longer needs the service • Discontinues from the services • Is incarcerated for a year or longer • Exhibits violent or threatening behavior that prevents the provision of a service or that prohibits another client from receiving services. • Has passed away Policies and procedures for discharge must include at least three (3) attempts to contact the client before discharge.	Added language surrounding "threatening behavior" in order to qualify the necessary impact of the behavior Removed "died" and added "passed away" for more respectful language Wrote out "three" for clarity

Section 5.1: Safety Protocol for Staff and Clients

Original Language	Edited Language	SPEC Rationale
Standard: 5.1 Safety protocol for staff and clients Agency must have a safety policy/protocol that is reviewed and signed by Part A staff members. Measure: A written policy is on file at the agency location	Measure: A written safety policy/protocol is on file at the agency location	Added language so that the measure more specifically mirrors that standard. Included this edit for specificity and clarity. **Similar suggested edits were made in sections 5.2, 5.3, 5.4, and 7.3

Section 11.1: Emergency Financial Assistance Assessment

Original Language	Edited Language	Rationale
Providers must demonstrate an urgent need resulting in client's inability to pay their utility bills or prescriptions without financial assistance for essential items or services necessary to improve health outcomes. For example, demonstrated need may be demonstrated by, but not limited to the following: • A significant increase in bills	Providers must demonstrate an urgent need resulting in client's inability to pay their utility bills or prescriptions without financial assistance for essential items or services necessary to improve health outcomes. For example, demonstrated need may be demonstrated by, but not limited to the following: • A significant increase in bills that prevents a client from addressing both basic needs to maintain positive health outcomes and the increased cost of bill(s).	Significant is open-ended but every situation is different and what is significant to one person may not be as impactful as someone else. This will also differ depending on the area given the size of the EMA. Proposed additions to help guide use of EFA to ensure it is used as a last resort for essential items to improve health outcomes (as specified in PCN 16.02)

Section 11.3: EFA Voucher

Original Language	Edited Language	SPEC Rationale
EFA Vouchers ***cannot be provided in the form of direct cash payment*** to a client. The use of store cards/gift cards with the Mastercard/Visa are considered cash payments and cannot be distributed to the client.	EFA Vouchers ***cannot be provided in the form of direct cash payment*** to a client. The use of store cards/gift cards with the Mastercard/Visa/ American Express logo are considered cash payments and cannot be distributed to the client.	Included additional bank company

VOTE

Motion to approve the FY24 Service Standards

Summary of Motion:

Vote to approve the FY24 Service Standards as reviewed and approved by the Services, Priorities and Evaluations Committee and Ryan White Services Division.

YES - You agree with SPEC's revisions to the Service Standards

NO - You do not agree with SPEC's revisions to the Service Standards

ABSTAIN - You wish not to vote on the motion

Breakout Rooms

Create a real-world example of how the Service Standards impact how agencies function.

This could be a story you create as a group, a situation that happened to you or in your agency, or a way in which you have seen the Service Standards impact the function of an agency.

10 minutes in groups, 15 minutes for discussion and sharing!

Clinical Quality Management Program Update
Boston EMA Planning Council

RYAN WHITE SERVICES DIVISION, INFECTIOUS DISEASE BUREAU

BOSTON PUBLIC HEALTH COMMISSION

FEBRUARY 9, 2023

Purpose & Objectives

- Anchor the Planning Council in the basics of Ryan White Clinical Quality Management Program (CQM)
- Communicate updates to the Planning Council on CQM accomplishments and challenges of FY 2022
- Share future directions of the Ryan White CQM Program with the Planning Council

What is Clinical Quality Management?

Quality

EFFICIENCY – Eliminate waste of time and effort

EFFECTIVENESS – Accomplish the intended purpose

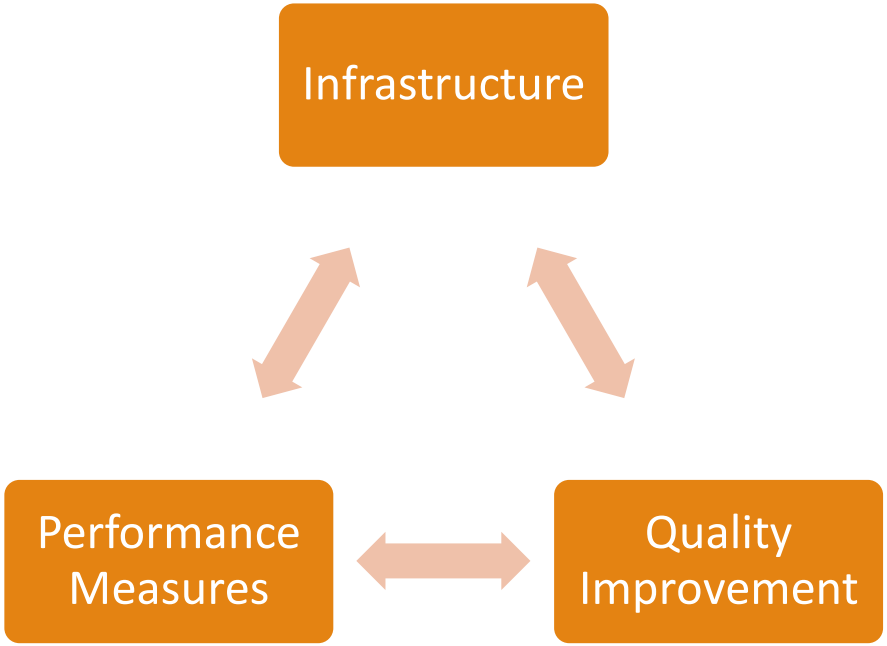
EQUITY – Ensure that opportunities for health are accessible to all

SATISFACTION – As measured by the consumer

Clinical Quality Management (CQM)

Quality Assurance	A broad spectrum of activities aimed at ensuring compliance with minimum quality standards
Quality Improvement	A deliberate process to continuously improve efficiency, effectiveness, equity, and satisfaction in the current system
Clinical Quality Management	The coordination of activities aimed at improving patient care, health outcomes, and patient satisfaction among PLWH/A

Ryan White CQM Program



FY22 CQM Program Updates

ACCOMPLISHMENTS OF THIS FISCAL YEAR

FY 2022-24 CQM Plan, Goal 1

To promote and sustain a culture of continuous Quality Improvement throughout the Ryan White HIV/AIDS Program in the Boston EMA, reflected in an increase of the Boston EMA Culture Assessment median score from 14 to 16 by January 2025.

- To deepen the bench of QI knowledge among Ryan White stakeholders.
- To increase the percentage of subrecipients with a written QI or QM plan from 70% to 90% by FY 2025.
- Support a CQM Committee, representative of the Boston EMA population that meets six times per fiscal year that advises on the development, annual revision, and implementation of the CQM Plan and corresponding activities.
- To increase the percentage of subrecipients who include client participation in QI discussions from 59% to 70% by FY 2025.
- To increase the percentage of subrecipients who have made improvements to health outcomes of at least 10% in 12 months from 53% to 65% by FY 2025.

FY 2022-24 CQM Plan, Goal 2

To increase the viral suppression rate among People Living with HIV/AIDS in the Boston EMA from 90% to 92% by FY 2025.

- To increase the percentage of clients who report “Excellent” adherence to ART from 81% to 90% by FY 2025.
- To increase the percentage of clients linked to care within 30 days of HIV diagnosis from 30% to 35% by FY 2025.
- To work collaboratively with People Living with HIV/AIDS and other HIV care stakeholders to reduce the stigma against HIV and its syndemics on an ongoing basis.

Revised CQM Staff Structure

Sarah Kuruvilla, MPH
Senior Program Manager, CQM

Claire Karafanda, MPH
Senior Program Coordinator, CQM
Performance Measurement

TBH
Senior Program Coordinator, CQM
Quality Improvement

Ryan White CQM Committee

- 13 members
- Representatives from MDPH and NHDHHS
- Comprised of providers, consumers, other stakeholders
- Will have met 6 times this year, virtually
- Provided input and feedback on:
  - CQM Planning
  - Performance Measures and Data Displays
  - QI Culture Assessment
  - Upcoming QI Learning Collaborative
  - Understanding program gaps (i.e. low 30-day Linkage to Care rate)

QI Mini-Grant Spotlight

- Project aimed to improve Casa Esperanza's existing client satisfaction process to be better targeted towards Ryan White clients and their HIV care experiences
- Casa Esperanza tested using Photovoice alongside a new client satisfaction survey and got a much richer picture of clients' experiences and needs than with the previous process

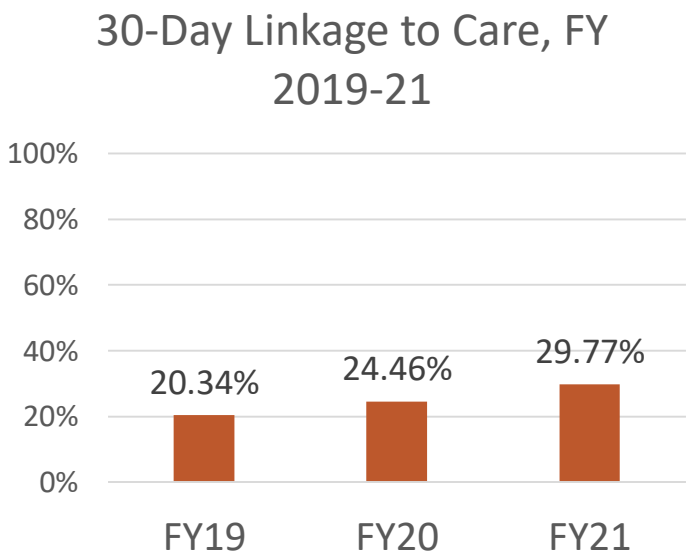
e2Boston Updates

- Included client totals in the Outcomes report
- Added a “Difference” column for HIV Care Continuum measures
- Began planning of a data alerts system for providers
- e2Boston Trainings

Investigation of 30-Day Linkage to Care Rate

- Very low 30-day linkage to care rate (20-30%) over the past few years
- Providers have reported that their linkage rates are not aligning with their experiences providing care
- Launching an investigation of:

1) e2Boston analysis of linkage to care
2) Data entry practices
3) Services and Models of Care



Other Accomplishments

- HRSA Virtual Site Visit
- Equitable Formative Evaluation Plan for a collaborative QI learning model
- 2023 QI Culture Assessment out now
- Communicating data to stakeholders better
  - New and improved quarterly data displays
  - Established regular communication structures with key partners
- Applying to participate in the 2023-24 ESCALATE Learning Collaborative

FY22 CQM Challenges & Future Directions

Challenges

- Limited program capacity
- Far less focus on Quality Improvement work and capacity-building

Future Directions

- Bring back focus on EMA-wide Quality Improvement with:
  - Quality Improvement Learning Collaborative
  - Tiered QI Learning approach based on culture assessment results
  - Creation of a QI resource library
  - Hire a Senior QI Coordinator with strategic recruitment
  - Recorded QI training content from CQM
- ESCALATE Collaborative
- Increase consumer involvement in EMA-wide QI discussions

Takeaways

- Vacancies limited scope of QI work
  - Staff structure updated from 2 Coordinators → CQM Manager, PM Coordinator, QI Coordinator
  - Currently recruiting new QI Coordinator
- Overall reinvestment in Performance Measurement
  - Improved communication of data to stakeholders
  - Improved quality of outcomes data

Thank You!

QUESTIONS?

ANNOUNCEMENTS & EVALUATION

Let us know about potential recruitment events!

- Google Form is on Basecamp: https://docs.google.com/forms/d/e/1FAIpQLSdajW6lUxy8fKn0Rak18oIPx3zXeZBvBl2V9EY50yUWHvD06Q/viewform
- Email pcs@bphc.org

PCS Office Hours

- Wednesdays, 12 – 1 PM, regular Zoom link

Research Participation Opportunity

- Dr. Brianne Olivieri-Mui from Northeastern

Any other announcements?