CQM Plan Review Checklist

The Clinical Quality Management Plan should address how the grant recipient will meet the key components of a clinical quality management program as outlined in [Clinical Quality Management Policy Clarification Notice 15-02.](#) There are also corresponding frequently asked questions for Clinical Quality Management Policy Clarification Notice 15-02.   The frequently asked questions address comment questions related to Clinical Quality Management.

The Clinical Quality Management Plan should provide a good understanding of the grant recipient's clinical quality management program in a narrative format. A clinical quality management plan is brief and to the point. It does not contain information tangentially related to the clinical quality management program (e.g. history of the grant recipient), which can be found elsewhere (e.g. grant application).

Section	Content	Present: Yes/No/Partial	Comments
General Information			
Include the name of the grant recipient and the date last updated or approved.	**Yes**-The cover page references: Pennsylvania Clinical Quality Management Plan, Ryan White & AIDS Drug Assistance Program. January 2021-January 2022. The date of the last revision will be added to the coversheet of the CQM Plan. This is the inaugural CQM Plan. The Signature Page is appendix K. Layout is clear, easy to follow and content is well organized. The content reflects significant introductory information due to the 2020 CQM Plan being the first published plan.	Consider a **cover page.** Include the timeframe the plan covers (e.g. April 2018 – March 2019) based on the evaluation period (e.g. calendar, grant, or fiscal/budget year). Include the last **month/date** the plan was revised/updated or if a new plan, its inaugural date. **Approval:** Note when it was approved, and by whom. Consider a signature page (Appendix document), with organizational hierarchy associated with the CQM program. Theoretically, individuals who

			reviewed, understands, agrees with, and subsequently approves the document. Ensure the layout is clear, easy to follow, and that content is well organized.

Quality Statement

PCN 15-02	None		
Narrative Description	• Brief, visionary, and related to HIV services • Describes the ultimate goal of quality efforts and the purpose of the program • Answer: How can client needs be met? • Answer: How can we ensure high quality care is provided while optimizing resources?"	**Yes**- The Department's BCD, Division of HIV Disease is committed to improving care, health outcomes, and client satisfaction for persons living with HIV/AIDS (PLWH). The CQM program utilizes an interdisciplinary and cross functional approach to ensure continuous monitoring, evaluation, and process improvement within the Ryan White Part B core medical and support programs. Pennsylvania strives to efficiently and effectively use federal and state resources to meet the care and support needs of our state. Therefore, we focus on aligning with state and federal health strategies and goals. To successfully align our initiatives, we communicate our HIV goals and strategies through participation in the Pennsylvania State Health Improvement Plan (SHIP) process. The mission of the BCD Division of HIV Disease is to reduce the incidence and prevalence of communicable diseases in the Commonwealth of Pennsylvania by providing a wide range of prevention and intervention strategies, which incorporate all aspects of government and community partnerships.	Demonstrates: 1. Equal access to quality comprehensive HIV care and support services. 2. Degree to which the performance of funded HIV care and support services achieve the standards. 3. How the program provides a continuum of care and eliminates health disparities across jurisdictions. **For example:** • Promotes quality medical care and support services based on current DHHS Guidelines and professional standards. • Maximizes retention in care. • Promotes accessible and appropriate HIV care and support services based on monitoring epidemiological trends. • Supports efficient and effective use of federal and state resources to meet the care and support needs.

			• Improves alignment across health districts by developing core performance measures. • Improves alignment across services through standardization of case management.
Annual Quality Goals			
PCN 15-02	None		
Narrative Description	• Outline year's priorities for the CQM program • Endpoints/conditions towards which program work will be directed • Focus on program's most important areas of need; emphasis on improvement • Five or fewer goals • Encourage to cover a 12-month period (but no longer than 18-months)	**Yes**- As part of technical assistance from HRSA, a CQM staff member was hired and tasked with rebuilding the CQM Program. The CQM strategies and goals were identified as part of the process to rebuild the program. A CQM Workgroup was established to review Performance Measure data, identify quality improvement project (s) and make recommendations for the plan to HPG. The CQM program will be responsible to ensure client needs are being met by: • Ensuring improved linkage and access to medical care and support services for HIV positive individuals who are aware of their status; • Enhancing the quality of services and outcomes; • Providing linkage to medical services and social support services; • Making changes to programs in order to align with identified trends/needs of the evolving epidemic;	**Accomplished by:** 1). Assessing where the program is currently (e.g. historical analysis, quality and reliability of data); 2). Quantifying where the program is heading. 3). Building workgroups (e.g. CQM Committee consensus). 4). Understanding program parameters (e.g. know your subrecipients and consumers); and 5). Prioritizing goals in all components of 15-02 (Infrastructure, Performance Measurement, and Quality Improvement). Ensure goals are: • **Relevant** (how significant is the problem?),

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Utilizing quality, epidemiological, claims, service, and outcomes data to establish priorities;
Ensuring accountability of resources related to performance and delivery of service.

Annual Goals for Calendar Year 2020:

Goal 1: Establish and Implement a CQM Program.
Goal 2: Align Ryan White HIV, Prevention, Care and SPBP data.
Goal 3: Develop consistent process for subrecipients to share provider location and contact information to the community on regional websites so that a statewide website of resources can be created.

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Impactful (what is the effect on the program?),
Feasible (can something be done about the problem with the resources available?)
Measureable (can numerical value including fiscal impact be demonstrated?), and
Realistic (are the goals achievable)?

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<tr>
<td colspan="4">**Quality Infrastructure**</td>
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<td>PCN 15-02</td>
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Utilization of Ryan White HIV/AIDS Program grant funds to establish an appropriate infrastructure for a clinical quality management program is allowed
An ideal infrastructure consists of: leadership, quality management committee, dedicated staffing, dedicated resources, clinical quality management plan, involvement of people with HIV, stakeholder involvement, and evaluation of the clinical quality management program

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| Narrative Description | • Describe how leadership guides, endorses, and champions the clinical quality management program | **Yes**-PCN 15-02 is referenced in the introdution of the CQM Plan document with a link for access. **Leadership:** HRSA requires Part B Grantees to ensure the appropriate and sufficient infrastructure is in place in order to make the CQM program successful and sustainable. The infrastructure is responsible for the planning, implementation, and evaluation of CQM activities. Within the BCD Division of HIV Disease implements and facilitates activities related to the CQM Plan. The CQM Coordinator provides general oversight of the CQM Plan, coordinates program evaluation and quality management activities, oversees service standards and outcome measurement activities, analyzes outcomes, and integrates data into reports.

Clinical Quality Management Organizational Members Chart is referenced in appendix A.

Dedicated Staffing:
The BCD Division of HIV Disease has a dedicated CQM Coordinator. The CQM Coordinator reports directly to the Program Manager for HIV Care. The CQM Coordinator is responsible for the development, review and revisions made to the CQM Plan.
Dedicated Resources:
For the CQM plan to be successful and execute the CQM activities, the process relies on data managers to assist with data collection, performance measurement, and to provide training and technical assistance for subrecipients. | Specify in brief detail. Have PCN 15-02 expectations been met?

Include the titles, roles, and responsibilities. Do not include people's names (staff and other stakeholders).

Consider including an organizational chart (Appendix document). |

		Clinical Quality Management Plan: Our CQM Plan describes all aspects of the CQM program including infrastructure, priorities, performance measures, quality improvement activities, action plan with a timeline and an evaluation of the CQM program. **Consumer Involvement:** PLWH involvement reflects the population being served and ensures the needs of PLWH are being addressed by CQM activities. Consumer involvement in the CQM Plan is obtained via the HPG QMAC and the CQM Workgroup. **Stakeholder Involvement:** Implementing quality management across the state requires input, buy-in and support from key stakeholders. Stakeholder involvement (i.e., subrecipient, other recipients in the region, planning body and/or its committees and/or consumers) provides input on CQM activities to be undertaken. Internal and external stakeholder involvement is obtained via the HPG QMAC, CQM Workgroup and BCD internal department participation and via the review of the CQM Plan annually. **HIV Planning Group (HPG) Quality Management Advisory (QMAC) Committee:** The HPG is a group of individuals united for the common purpose of contributing to HIV care and	

| | | prevention across the Commonwealth of Pennsylvania. The HPG provides a forum to solicit such input as membership is comprised of PLWH and members across the commonwealth; is reflective of services provided through all RWHAP (A, B, C, D, and F); data managers; the HIV and Hepatitis epidemiologist; and program administrators of HIV. The HPG QMAC provides committee oversight and recommendations to the plan, with the department having the ultimate decision making authority.The CQM Plan is a component of the larger HPG Plan. Implementing quality management across the state requires input, buy-in and support from key stakeholders. With direct oversight of the CQM Plan by HPG, the HPG QMAC is responsible for reviewing data in order to identify trends, develop priorities, and set quality improvement goals and measures. Additional responsibilities include the review and implementation of the CQM Plan, the review of the Pennsylvania Ryan White Part B service standards, and the development of strategies to improve care processes. The HPG QMAC meets quarterly to review system-wide quality management issues, challenges, and to develop strategies to improve care. They also provide input and recommendations to the BCD Division of HIV Disease on other care and prevention related issues. The HPG QMAC has the authority to delegate responsibilities of the Plan to the CQM Workgroup. | |

		Clinical Quality Management Workgroup: Workgroup members are selected from the larger HPG QMAC as well as representation of our seven Regional Grantees and meet regularly and/or as needed. The primary focus of the CQM workgroup will be to review data, the implementation of the CQM Plan as well as a progress review of the CQM plan. These initiatives will be accomplished through developing priorities and identifying Quality Improvement Projects (QIPs) based off clinical data. Quarterly reports will be provided to the HPG QMAC regarding trends and/or performance improvement initiatives. **Evaluation of the CQM Program:** Evaluating the effectiveness of the CQM program helps to ensure the CQM activities are making changes that positively affect outcomes. The HPG QMAC will evaluate the plan using the CQM Plan Review Checklist which helps ensure that the plan contains all the necessary components and meets the federal requirements of HRSA. The HPG QMAC is expected to review the plan and make recommendations to it on an annual basis. The CQM workgroup will review provider performance data with the HPG QMAC quarterly during HPG meetings. Based on outcomes, QIPs can also be suggested and initiated. The HPG QMAC solicits feedback from subrecipients and consumers on overall quality improvement and effectiveness of the plan. These steps are important in order to	

		improve the quality of care and promote a more coordinated health care response to PLWH.	
	• Describe who serves on the quality management committee, who chairs and facilities the meetings, how often the quality management committee meets, and the purpose of the quality management committee	**Yes**- **Clinical Quality Management Workgroup:** Workgroup members are selected from the larger HPG QMAC as well as representation of our seven Regional Grantees and meet regularly and/or as needed. The primary focus of the CQM workgroup will be to review data, the implementation of the CQM Plan as well as a progress review of the CQM plan. These initiatives will be accomplished through developing priorities and identifying Quality Improvement Projects (QIPs) based off clinical data. CQM Workgroup meeting minutes are maintained and facilitated by the Director & Co-PI, HIV Prevention and Care Project/Co-Director, Center for Mindfulness and Consciousness Studies/Instructor, Dept. of Infectious Diseases and Microbiology, University of Pittsburgh. Quarterly reports will be provided to the HPG QMAC regarding trends and/or performance improvement initiatives.	Specify in brief detail, particularly the committee's purpose. Note roles and responsibilities of members. Are meeting minutes maintained? How? By whom? *Committee Charter (bylaws) – an internal document often used to detail how the CQM committee is structured and its standard operating procedures.*
	• Describe the staff positions responsible for developing and implementing the clinical quality management program and related activities	**Yes**-The CQM Plan is updated annually by the CQM Coordinator based upon input from the HPG QMAC, CQM workgroup, SPBP Advisory Council and internal DOH staff. The following areas are assessed:	Specify in brief detail. *(Note: Some plans have staff position descriptions copied/pasted directly from the grant application.)* Consider using job titles versus staff names (including contractors).

	including the role of contractors funded to assist with the clinical quality management program	• Routine CQM workgroup meetings occur as required and/or as needed; • The monitoring and evaluation of the effectiveness of quality management activities, objectives and approaches; • The implementation of QIPs to improve or resolve deficiencies that have been documented; • The monitoring of work plan activities at least quarterly by the CQM Coordinator and reviewed with the HPG QMAC. Updates and progress are shared at the QMAC quarterly meetings. The work plan is attached as Appendix H: Annual Work Plan and Quality Goals Timeline. At this time, CQM precific language is not referenced in the contracts the department has with subrecipients/sub-subrecipients.	*Staff Position Descriptions:* Consider mentioning value of reviewing to ensure CQM program related roles and responsibilities included. Revise with leadership if language is either vague or nonexistent. *Contractual language:* Consider the same approach (review) to subrecipient contracts (if applicable).
	• Describe who writes, reviews, updates, and approves the clinical quality management plan	**Yes**-CQM Coordinator updates the CQM Plan in collaboration with the input from the CQM Workgroup and progress is shared at the QMAC quarterly meetings. The work plan is attached as Appendix H: Annual Work Plan and Quality Goals Timeline.	Specify in brief detail. Does it include all components? *(Quality Statement, Annual Quality Goals, Infrastructure, Performance Measurement, Quality Improvement, Evaluation of the Program, Work Plan).* How often is the CQM plan reviewed and revised? By whom? What is the process in updating the work plan? How often?

			What is the approval process that finalizes the plan?
	• Describe how people with HIV are involved in the development and implementation of the clinical quality management program	**Yes**- **HIV Planning Group Quality Management Advisory Committee** (HPG)**:** The HPG is a group of individuals united for the common purpose of contributing to HIV care and prevention across the Commonwealth of Pennsylvania. The HPG provides a forum to solicit such input as membership is comprised of PLWH and members across the commonwealth; is reflective of services provided through all RWHAP (A, B, C, D, and F); data managers; the HIV and Hepatitis epidemiologist; and program administrators of HIV. Department staff, subrecipients/sub-subrecipients, and consumers are also represented on the CQM Workgroup. No particular subpopulations are sought as participants. The CQM Coordinator distributed an email to the HPG members to determine interterest in participating in the CQM Workgroup.	Specify in brief detail. Discuss CQM committee structures; their roles and responsibilities. How are people with HIV recruited? Are particular subpopulations (e.g. transgender, youth) sought as participants?
	• Describe how stakeholders (e.g. subrecipients, other recipients in the region, planning body/committee, etc.) provide input into the clinical quality management activities	**Yes**-The HPG is a group of individuals united for the common purpose of contributing to HIV care and prevention across the Commonwealth of Pennsylvania. The HPG provides a forum to solicit such input as membership is comprised of PLWH and members across the commonwealth; is reflective of services provided through all RWHAP (A, B, C, D, and F); data managers; the HIV and Hepatitis epidemiologist; and program administrators of HIV.	Specify in brief detail. *Part A programs:* Detail information related to the Planning Council/Body. Detail information about Consumer/Client Advisory Boards.

		The HPG QMAC delegated the CQM Plan and quality improvement activities to the CQM Workgroup. Input is obtained from CQM Workgroup members during regularly scheduled meetings and reflected in meeting minutes. Membership of the CQM Workgroup is reflective of PLWH, HPG members, department staff members as well as at least 1 representative from each of the (7) RW Part B regions in Pennsylvania.	What are leaders/staff doing to establish a regional reach of CQM program collaborations?
	• Describe how the effectiveness of the clinical quality management program is evaluated	**Yes**-Evaluation of Clinical Quality Management Program: Evaluating the effectiveness of the CQM program helps to ensure the CQM activities are making changes that positively affect outcomes. The HPG QMAC will evaluate the plan using the CQM Plan Review Checklist which helps ensure that the plan contains all the necessary components and meets the federal requirements of HRSA. The HPG QMAC is expected to review the plan and make recommendations to it on an annual basis. The CQM workgroup will review provider performance data with the HPG QMAC quarterly during HPG meetings. Based on outcomes, QIPs can also be suggested and initiated. The HPG QMAC solicits feedback from subrecipients and consumers on overall quality improvement and effectiveness of the plan. These steps are important in order to improve the quality of care and promote a more coordinated health care response to PLWH.	Briefly detail the process: 1). How often is the program's effectiveness discussed? By whom? *(CQM committee agenda item?)* 2). How is leadership informed of program progress issues? How often? Through what means? 3). How and when are evaluation findings shared? With whom? 4). How are ineffective CQM activities addressed?
Performance Measurement			

CQM Plan Review Checklist

PCN 15-02	• Recipients are strongly <u>encouraged</u> to include HRSA HIV/AIDS Bureau (HAB) measures, Health and Human Services (HHS) guidelines, and the National HIV/AIDS Strategy (NHAS) indicators.
	• Data collection and analysis for the CQM performance measures should occur quarterly at a minimum.
	• For RWHAP service categories funded by direct RWHAP funds, rebates, and/or program income:
	   o Recipients should identify at least two performance measures where greater than or equal to 50 percent of the recipients' eligible clients receive at least one unit of service;
	   o Recipients should identify at least one performance measure where greater than 15 percent and less than 50 percent of the recipients' eligible clients receive at least one unit of service; and
	   o Recipients do not need to identify a performance measure where less than or equal to 15 percent of the recipients' eligible clients receive at least one unit of service.		

Narrative Description	• Describe how performance measures are selected and regularly reviewed for relevance, need, etc.	**Yes**-Requirements for the Ryan White Grantees to use the PHS guidelines are communicated via [the Health Resources and Services Administration (HRSA) Federal Policy Clarification Notice 15-02.](#) Performance Measures for Ryan White Part B must be selected by determining the percentage of Ryan White clients receiving at least one unit of service for a service category.
		Ryan White Part B performance measures are selected by identifying the unique number of clients receiving a Ryan White service as the denominator. Using the number of unique clients utilizing each Ryan White funded service, and the following HRSA formula, determine the number of performance measures per service that are needed for the CQM Plan.
		
		  Determination Method used for Performance Measure requirements:
		
		    • > = 50 percent - 2 performance measures
			Specify in brief detail. Have PCN 15-02 expectations met?
			
			Are the measures appropriately reflective of RWHAP-funded services?
			
			Are the measures relative to the local HIV epidemiology?
			
			Do the meaaures identify the needs of people with HIV?
			
			What is the selection process, and who is involved? *(Note: recipient needs service utilization data)*

		• > 15 percent to < 50 percent - 1 performance measure • < = 15 percent - no performance measures	
	• Describe the process to collect performance measure data including engagement of subrecipients.	**Yes**-The following data management systems were used to collect RW B client level data: CAREWare data, surveillance data and SPBP data. The CAREWare data is transferred from the subrecipient/sub-sub recipient to the departments secured portal (sFTP).	Specify in brief detail. How are subrecipients involved? What is the primary source of data? What data management system(s) are used and in what data system is data stored? How is data transferred (e.g. all data is entered in one system; manual entry by subrecipient; data is emailed in Excel file or faxed to recipient; etc.)?
	• Describe the process to analyze the performance measure data including stratifying the data to identify health disparities and sharing the data with stakeholders.	**Yes**-The BCD Division of HIV Disease has a dedicated CQM Coordinator. The CQM Coordinator reports directly to the Program Manager for HIV Care. The CQM Coordinator is responsible for the development, review and revisions made to the CQM Plan. Quarterly data reports will be provided to internal and external stakeholders via the HPG QMAC, by the CQM Coordinator, regarding trends and/or performance improvement initiatives. To date, the most recent data results available and reported are 2021 quarterly reports. Data reports are provided to the CQM Coordinator from department Data Managers. A Data Manager	Specify in brief detail. Who is responsible for analyzing and articulating findings? Is data stratified? How? What are the most recent data available? How are data results reported? How are results and findings disseminated? To whom?

		compiles the stratified data into regionl specific spreadsheets and a data visualization report specifically for the CQM Performance Measures. Data reports are made available to our 7 subrecipients by posting them on the Regional Grantee SharePoint. The CQM Coordinator also conducts quarterly 1:1 Data Visualization report reviews with each of the 7 subrecipients/sub-subrecipients. The quarterly data reports are also shared with the CQM Workgroup to assist in quality improvement activities.	How is data used to drive CQM activities?
	• Identify performance measures for all Ryan White HIV/AIDS Program funded service categories.	**Yes**-Appendix C: Ryan White Funded Service Category List and Appendix D: Unique Clients by Service Category	Consider listing all RWHAP-funded service categories and associated performance measures (Appendix document).

Quality Improvement			
PCN 15-02	• Recipients are expected to implement quality improvement (QI) activities using a defined approach or methodology (e.g., model for improvement, Lean, etc.). • Documentation of all quality improvement activities. • Recipients should conduct QI activities within at least one funded service category at any given time. (QI project may span multiple service categories.)		
Narrative Description	• Describe the QI approach or methodology used (e.g. Model for improvement/PDSA, Lean, etc.)	**Yes**- A systematic approach to the continuous study and improvement of processes. Quality Improvement typically results in the elimination or reduction of rework, waste, and losses in processes. It includes a cross-functional team with a client-driven philosophy and process that prevents problems, recognizes problems, and maximizes the quality of care.	Specify in brief detail. Are PCN 15-02 expectations met?

| | | In alignment with the Governor's Office of Operational Excellence, our Quality Improvement process uses the Plan, Do, Study, Act (PDSA) cycle for assessing a process; determining if there are better or new ways to handle the process; implementing changes and monitoring those changes after implementation. In addition to the PDSA cycle, the Lean Six Sigma methodology is also incorporated into Process Improvement activities for problem analysis.

Plan, Do, Study, Act Cycles:
The PDSA cycle methodology is a model for performance improvement used for quality improvement projects, utilizing the following cycle:

• ***Plan***- Identify and analyze what you intend to improve, looking for areas that hold opportunities for change.

• ***Do*** - Carry out the change or test on a small scale (pilot).

• ***Study***- Complete analysis and synthesis and compare data to prediction in Plan stage. Record under what conditions the results could be different. Summarize what was learned, identify if changes led to improvements in the way you had hoped and consider next steps.

• ***Act***- Adopt the change, abandon it, or initiate a new PDSA cycle. | |
| | • Describe how QI priorities or projects | **Yes**- Performance measurement is the process of collecting, analyzing, and reporting data regarding | Is performance data used to develop QI activities? How? |

	are selected; if known, state the QI priorities or projects for current year	client care, health outcomes on an individual or population level and client satisfaction. In order to appropriately assess outcomes, measurement must occur. The HIV/AIDS Bureau Performance Measures focuses on elements most critical to the care and treatment of PLWH. Performance Measures will be selected by which best assess the services provided to recipients of the Pennsylvania Ryan White Part B grant. Ryan White Part B, epidemiological and SPBP data will be collected on a routine basis in order to analyze the data for disparities in care and measurement over time. The CQM Workgroup selected Medical Case Management, Viral Load Suppression as our first quality improvement initiative.	
	• Describe how QI projects are documented	Quality Improvement Projects are documented via CQM Workgroup meeting minutes and included in the quarterly reports to the HPG QMAC. The meeting minutes are posted on the STOP HIV as well as a SharePoint accessible to our subrecipients/sub-subrecipients.	Specify in brief detail.
	• Describe how subrecipients are engaged, supported, and monitored with respect to QI	The CQM Coordinator has provided Technical Assistance to subrecipients regarding the CQM Plan and the expectations of the department. Updates to CQM related activity is discussed during the department's monthly conference/video call with the subricipients. The CQM Coordinator has quarterly 1:1 meetings with each subrecipient to review their CQM Performance Measure outcome data. The CQM Coordinator participates in Annual Site Visits to review the subrecipient Quality	Have QI capacity building (e.g. training opportunities) needs of staff and subrecipients been assessed, identified, and implemented? Describe and briefly detail.

Has technical assistance on QI and support for QI activities been identified? To whom? Briefly detail. |

			Management Plan and their active participiation in the CQM Plan via the CQM Workgroup. CQM Workgroup members were provided with Technical Assistance specifically relating to the Lean method of process improvement in 2021. CQM Workgroup minutes are posted on the Regional Grantee SharePoint as well as on the STOPHIV website.	How is data fed back to providers and key stakeholders? Into the recipient's CQM program (if applicable)?
Work Plan				
Narrative Description	•	A work plan created to provide a thorough overview of implementation: establish timelines, milestones, and accountability for all clinical quality management program activities outlined in the clinical quality management plan.	**Yes**-The Work Plan is appendix H. The Work Plan has 3 specified goals: (1)Establish and implement a CQM Plan, (2) Align Ryan White HIV, Prevention, Care and SPBP data & (3) Develop consistent process for subrecipients to share provider location and contact information to the community on regional websites so that a statewide website of resources can be created. Each Work Plan goal has specific and measurable action steps.	**Be detailed.** Review regularly. Either use the work plan to tell the story of those CQM program activities ainmed at achieving goals or reference where the activities are detailed (e.g. committee meeting minutes). Include the 5 W's and How.
	•	Table format may be used with columns for goal/objective, key activities/milestones, timelines (deadlines), responsible staff person(s) [accountability], and outcomes/impact	**Yes**-The Work Plan, appendix H is in table format with the following headers: Key Action Step, Person/Agency/Group Responsible and Timeline.	Include both successes and difficulties.
	•	Describe how the work plan will be	**Yes** -The CQM Plan in its entirety, which includes the Work Plan, was reviewed and provided to	Include this in the body of the document (e.g. evaluation).

	shared/communicated with all stakeholders, including staff, consumers, board members, parent organizations, other grant recipients, funders, etc.	subrecipients and/or sub-sub recipients, provided to The HPG (with a presentation on key elements of the CQM Plan), posted on the Regional Grantee SharePoint and also posted on the internal departmental SharePoint for reference.	