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Clinical Quality Management Plan
Ryan White Part B Program

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RYAN WHITE HIV/AIDS PROGRAM PART B GRANT RECIPIENT

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Glossary

- **A3—**a structured template for systematic problem solving based on the principles of Plan Do Study Act (PDSA).
- **ADAP**—the AIDS Drug Assistance Program: the Program within the Ryan White Part B Program that provides two services: ADAP-Medication Assistance (ADAP-M) and ADAP-Health Insurance Assistance (ADAP-I). The "Utah ADAP" refers to both services unless otherwise specified.
  ADAP-I—the Health Insurance Assistance Services through the Utah Ryan White Part B Program AIDS Drug Assistance Program (ADAP).
  ADAP-M—the Medication Assistance Services through the Utah Ryan White Part B Program AIDS Drug Assistance Program (ADAP).
- **Benchmark—a** comparison of performance metrics to industry outcomes or standards of care.
- **BEST**—the Bureau of Epidemiology Success Team, a team focused on quality throughout the bureau comprised of representatives from each program within the BOE
- **BOE**—the Bureau of Epidemiology
- **CAC**—the Community Advisory Council, consists of members of the Utah HIV community that assist in providing direction to the Ryan White Part B Program.
- **CAP**—the Corrective Action Plan
- **COA**—cadence of accountability
- **Community Partners**—stakeholders, external partners and members of the HIV community.
- **CQI**—Continuous Quality Improvement
- **CQM**—Clinical Quality Management
- **CQM Plan**—the document that describes how the grant recipient will meet key components of a Clinical Quality Management Program.
- **HAB**—the HIV/AIDS Bureau
- **HIV**—human immunodeficiency virus
- **HRSA**—the Health Resources and Services Administration: The federal entity that administers Ryan White funding.
- **Identifying Party**—the person or entity that is recommending an identified QIP
- **MCM**—medical case management
- **National Monitoring Standards—**designed to help Ryan White HIV/AIDS Program Part A and B grantees to meet federal requirements for program and fiscal management, monitoring, and reporting to improve program efficiency and responsiveness.
- **NMCM**—non-medical case management
- **OAMC**—outpatient ambulatory medical care
- **PCN**—Policy Clarification Notice
- **PDSA**—Plan, Do, Study, Act
- **PLWH**—all people living with HIV and AIDS inclusively. If a distinction is required between HIV and AIDS, PLWH refers to individuals living with HIV who have not received an AIDS diagnosis, and PLWA refers to individuals living with an AIDS diagnosis.
- **PM**—performance measure
- **PMM**—Performance Management Model
- **Program**—the Utah Ryan White Part B Program and all related services, including ADAP-M, ADAP-I, Core Medical and Support services.
- **Program Administrators**—ADAP, Part B and ClientTrack administrators and Part B manager
- **QA**—quality assurance: consists of planned and systematic activities implemented in a quality system so quality requirements for a product or service will be fulfilled (American Society for Quality).

- **QI**—Quality Improvement: the use of a deliberate and defined improvement process which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.
- **QIP**—Quality Improvement Project
- **QIP Team**—the individuals participating in the QIP
- **Quality**—the degree to which a health or social support service meets or exceeds established professional standards and user expectations.
- **Quality Management Plan**—a written document that outlines the grantee-wide HIV quality program, including a clear indication of responsibilities and accountability, performance measurement strategies and goals, and collaboration of processes for ongoing evaluation and assessment of the program.
- **Quality Management Program**—encompasses all grantee-specific quality activities, including the formal organizational quality infrastructure (e.g., committee structures, roles for stakeholders, providers, and clients) and quality improvement-related activities (performance measurement, quality improvement projects, and quality training activities).
- **Quality Management Team**—the HIV Quality Nurse Consultant, the HIV Quality Coordinator and the BEST Program representative(s)
- **RWB**—Ryan White HIV/AIDS Program Part B**:** this is the portion of the Treatment Extension Act of 2009 (Public Law 111-87) which provides grants to States and Territories to improve the quality, availability, and organization of HIV health care and support services for PLWH.
- **Ryan White HIV/AIDS Treatment Modernization Act**—the federal legislation created to address the health care and service needs of people living with HIV disease and their families in the United States and its Territories. It was enacted in 1990 as the Ryan White Comprehensive AIDS Resources Emergency CARE Act, reauthorized in 1996, and again in 2000. In 2006, it was reauthorized as the Ryan White HIV/AIDS Treatment Modernization Act and in 2009 as the Ryan White HIV/AIDS Treatment Extension Act.
- **Strategy—**a method or plan of action, a high-level approach that is feasible and influenceable, and when properly executed, will help achieve its higher objective or goal.
- **UAF**—the Utah AIDS Foundation; a community-based organization. A non-medical case management (NMCM) and emergency financial assistance (EFA) service provider for RWB clients.
- **UDOH**—the Utah Department of Health: the grantee in Utah that receives Ryan White Part B funding from HRSA to provide Core Medical and Support services, including ADAP-M and ADAP-I.
- **UHPG**—the Utah HIV Planning Group: formed in 2013 in response to a request by the Centers for Disease Control and Prevention (CDC) and HRSA that HIV prevention, treatment, and care planning be integrated. This is the state of Utah's public advisory planning committee and is composed of clients, service providers, government agencies including representatives of the UDOH RWB and HIV Prevention programs, and advocates/other interested parties. Other group members include individual, organizational, and community advocacy groups, public and private medical/behavioral agencies, minority, and refugee agencies. It provides perspective, experience, and expertise to the RWB planning process identifying specific strategies to ensure a coordinated and seamless approach to accessing HIV prevention, care, and treatment services for those infected with HIV, and those at highest risk for contracting HIV, particularly minorities, and other disenfranchised communities such as refugees and Native Americans. The UHPG's goals are to: 1) identify programmatic priorities in order to maximize current funding and 2) develop an HIV service delivery model that follows HRSA and CDC guidelines.

- **University of Utah, Infectious Disease Clinic (IDC)**—an outpatient ambulatory medical care (OAMC), medical case management (MCM), and NMCM service provider for RWB clients. Formerly known as Clinic 1A.
- **Work Plan—**outlines the quality and performance activities planned to enhance the value delivered to RWB clients and various stakeholders.

Introduction

The CQM plan describes RWB infrastructure, priorities, performance measures, quality improvement activities, action plan/timeline, and evaluation. RWB strives for a culture of CQI by following a deliberate and defined improvement process, focused on activities to meet community needs and improve population health. This requires continuous and ongoing efforts to achieve and maintain quality care.

Mission/Purpose

The mission of the Utah Department of Health (UDOH) is to protect the public's health through preventing avoidable illness, injury, disability and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles.

Vision

Our vision is for Utah to be a place where all people can enjoy the best health possible, where all can live and thrive in healthy and safe communities, that PLWH will be identified, appropriately treated, and achieve optimal health status along with a reduction in new HIV infections.

Values

- Respect—we show respect to all individuals with whom we interact. We provide quality customer service. We create a workplace culture where we value, honor, and care for each other. We value differing opinions as part of a healthy dialogue.
- Integrity—our actions reflect an absolute commitment to ethical and honest behavior. We are straightforward and transparent with each other, our partners, and the people of Utah.
- Collaboration—we engage each other, our partners, and the people of Utah in decision-making, planning, and integrated effort. We strive to work effectively with others. We recognize the value of input and opinions gleaned from diverse populations and people.
- Evidence-based—we provide health programs that benefit the people of Utah. We make innovative, insightful, and effective decisions based on good science and current accurate guidelines and budget. We do the right things in order to produce the greatest benefit and the greatest return on the public's investment.

Quality Statement

The Utah Ryan White Part B (RWB) Program quality statement is driven by UDOH strategic priorities of the healthiest people and a great organization. RWB commits to improving health outcomes through improvement of client care and satisfaction for PLWH in Utah. We partner with internal and external stakeholders, the CQM Committee, providers, and clients to provide a comprehensive, client-centered continuum of care and to meet or exceed legislative requirements for quality management, core medical care, and support services.

The Utah RWB bridges gaps for people living with HIV to access services and medications to increase viral suppression and reduce transmission of HIV. We seek to protect and improve the overall health of Utah's vulnerable populations, decrease health disparities, and increase health equity.

Priorities

RWB priorities include:

1. Customer—including improvement in healthcare, outcomes and satisfaction for clients served
2. ClientTrack—a system designed to integrate program, client and provider functionality
3. Utah Getting to Zero New HIV Infections
4. Establishing a culture of CQI

Goals

Goal 1. Increase viral suppression rate for all Ryan White B clients from a 2020 baseline of 88.9% to 91% by December 2021.

Goal 2. Establish a process to regularly assess and improve RWB customer satisfaction by December 2021.
Objective: Assess Ryan White B Client (customer) satisfaction, implement and evaluate one or more improvements as a result of the satisfaction assessment by December 2021.

Quality Infrastructure

Leadership

It is important for leadership to champion the CQM program and commit to culture of continuous quality improvement. They show support by providing resources for training and quality management operations.

The Utah HIV Planning Group (UHPG) seeks to enhance communication and improve efficiency across the HIV continuum of care. RWB collaborates with UHPG, Ryan White C and D grantees, and the AIDS Education and Training Center. The integrated collaboration minimizes duplication, increases data utilization efficiency, provides opportunities to share information and resources to meet community needs.

Dedicated Resources

Dedicated resources include:

- Education for RWB staff required to maintain competency. This includes attendance to conferences, webinars, classes, technical training, meetings, and other identified resources.
- Training for RWB staff, providers, clients, and stakeholders to support collaboration and the quality management process to set priorities, identify opportunities and strategies for improvement, and implement activities to achieve goals and objectives.
- Time, tools, and personnel to prepare committee meetings, share progress with stakeholders, and maintain CQM operations.

Clinical Quality Management Plan

The Clinical Quality Consultant is responsible to write, review, and update the CQM plan annually. Stakeholders annually review, provide feedback, and approve the plan.

Client Involvement

We welcome and actively recruit RWB clients to participate in development and implementation of the CQM Plan. RWB clients are invited to join the CQM Committee, the Community Advisory Committee (CAC), and Town Hall meetings. Ideally, the RWB client CQM Committee member communicates updates and activities at the CAC meetings.

Stakeholder Involvement

Stakeholders include internal and external partners, contracted providers, clients, and the community.

Stakeholder Responsibilities:

- Attend and participate in RWB CQM Committee meetings, QI initiatives, and focus groups
- Share information, communicate changes, and updates with representative agencies or other HIV related planning groups

Dedicated Staffing

UDOH RWB staff integrate with and support the CQM Plan responsibilities as outlined below.

- *ADAP Administrator*
    - Attend and support the CQM Committee
    - Guide services related to ADAP and Support Services
    - Maintains RWB Universal, ADAP, and Cost-Sharing Assistance (CSA), Service Standards
    - Contract administrator for/Benefits Specialist/CSA
- *ClientTrack Administrator*
    - Attend and support the CQM Committee
    - Guide operations related to ClientTrack
- *HIV Prevention Specialist*
    - Guide RWB related to Early Intervention Services (EIS)
    - Maintain EIS Service Standards
- *HIV Quality Nurse Consultant*
    - Chair CQM Committee, prepare agenda, update work plan
    - Guide and facilitate quality management
    - Provide quality program technical assistance, training, compliance monitoring, and reporting
    - Contract monitoring and compliance, support CAP development as indicated
    - QI monitoring and reporting activities
- *Part B Administrator*
    - Participate in the CQM Committee to guide, support, and represent RWB Core Medical and Support Services
    - Contract administrator for RWB Case Management/OAMC/Emergency Financial Assistance services/Transportation/Oral Health
    - Maintains RWB Universal, Case Management, OAMC, and Support Service Standards
    - Monitor CAP compliance and completion
- *Quality Coordinator*
    - Co-chair CQM Committee
    - Assist with work plan update
    - Guide and facilitate quality management
    - Provide quality program technical assistance, training, compliance monitoring, and reporting
    - Contract monitoring and compliance, support CAP development as indicated
    - QI monitoring and reporting activities
- *Ryan White Part B Program Manager:*
    - Attend and support the CQM Committee
    - Guide RWB client services, ADAP, and grant administration
- *Surveillance Manager*:

- Guide and support statewide surveillance operations, data abstraction, analysis and reporting

Clinical Quality Management (CQM) Committee

The CQM Committee meets quarterly. Committee members are selected as representatives along the HIV Care Continuum. The CQM Committee members collaborate to review performance and provide guidance and support to achieve program goals identified in the CQM Plan. Members include leadership, stakeholders, partners, service providers, clients, and coordinators. Internal UDOH CQM Committee stakeholder responsibilities are described in the dedicated staffing section. Other CQM Committee member responsibilities are described below.

CQM Committee Member Role and Responsibility

- *Benefits Specialist*—RWB client guidance and support from first contact, application completion, and re-certification for enrollment in core medical and support services.
- *Case Management*—Guidance and support from engagement through ongoing compliance for RWB clients requiring case management and support services.
- *Community Partners*—Guidance and support from the community.
- *Community (PLWH) Stakeholders*—Guidance and support from client perspective.
- *Outpatient Ambulatory Clinic Physician Assistant*—Guidance and support from engagement to sustained viral suppression and advisory on all aspects of HIV medical care. Quality contact and liaison from clinic.
- *Outpatient Ambulatory Clinic MD*—Guidance and support from engagement to sustained viral suppression and advisory on all aspects of HIV medical care.
- *Outpatient Ambulatory Clinic Administration*—Guidance and support for contractual care provisions.
- *Pharmacist*—Guidance, engagement, adherence, sustained viral suppression support, and advisory on all aspects of antiretroviral therapy.

Performance Measurement

Performance measurement is the process of collecting, analyzing, and reporting data regarding patient care, health outcomes, and patient satisfaction on an individual or population level. Measures assess the services the grantee is funding and reflect local HIV epidemiology-identified needs of PLWH. Performance measurement selection considerations include the following:

1. Data required to support or measure progress.
2. Ability to meet program goals and priorities.
3. Deficiencies identified by quality performance and quality assurance monitoring.
4. Collaboration with internal and external partners for most meaningful measures.
5. Clinical guidelines providing evidence-based recommendations for standards of care.
6. HRSA experts and other leaders in the field of HIV complementary clinical protocols and practices to provide effective HIV care delivery.
7. HRSA HIV/AIDS Bureau performance measure portfolio. The measurement portfolio focuses on critical areas of HIV care and treatment and aligns with milestones along the HIV care continuum.
8. National HIV/AIDS Strategy
    a. Reduce mew HIV infections
    b. Increase access to care and improve health outcomes for PLWH
    c. Reduce HIV-related disparity and health inequity
    d. Achieve a more coordinated national response to the HIV epidemic
9. The number of HRSA required performance measures are based on eligible client service utilization where the client receives at least one unit of service per Policy Clarification Notice #15-02.

Service Category Funded by direct RWHAP funds, rebates, and/or program income	Percentage of Utilization	Required # of PMs
	≥ 50%	2
	≥ 15% and < 50%	1
Performance measures not required for service category	< 15%	0

HRSA Required Performance Measures for Service Category Utilization Greater than 15%

Service Category	Performance Measure
ADAP combined: 66%	Percentage of RWB ADAP clients with a HIV viral load < 200 copies/ml at last HIV viral load test during the measurement year
	Percentage of RWB ADAP applications approved or denied for new ADAP enrollment within 14 days (two weeks) of ADAP receiving a complete application
Medical Case Management (MCM): 20%	Percentage of MCM clients, regardless of age, with a diagnosis of HIV who had an MCM service plan developed and/or updated two or more times which are at least three months apart in the measurement year
	Percentage of RWB MCM clients with a HIV viral load < 200 copies/ml at last HIV viral load test during the measurement year
Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services. Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas treatment adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category	
OAMC: 25%	Percentage of RWB OAMC clients, regardless of age, with an HIV viral load < 200 copies/ml at last HIV viral load test during measurement year
	Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services
Oral Health: Service Utilization 30%	Percentage of RWB oral health clients who had a diagnostic or preventive service at least once in the measurement year
Nonmedical Case Management (NMCM) 72%	Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services. Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas treatment adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.
	NMCM Services have as their objective providing coordination, guidance, and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

Data Collection, Analysis, and Reporting

Grant recipients provide guidance to subrecipients and contracted providers on prioritizing measures and methods for data collection. Data for performance measurement may be collected and entered by UDOH RWB staff, and/or subrecipient. Performance improvement data is collected and reported quarterly. Systems and processes used for data collection include both internal and external mechanisms. This may include survey tools, spread sheets or web-based programs.

Measure	How Collected	Responsible for Collection	Responsible for analysis	Collection Frequency	Data Sharing
ADAP Services	SGRX & RWB Spreadsheets	RWB ADAP Administrator	RWB ADAP Administrator	Quarterly	• RWB CQM, CAC Committees • RWB Leadership • UHPG
MCM Service Plan	Redcap or EPIC	Subrecipient	CQM Committee		
MCM Viral Suppression	EPIC	Subrecipient	CQM Committee		
OAMC Viral Suppression	EPIC	Subrecipient	CQM Committee		
Oral Health	Through encrypted email	RWB Administrator	RWB Administrator		

Grant recipients collaborate with subrecipients to establish the process to collect and analyze data (e.g., calculate the numerator, denominator, and percentage). The analysis process includes:

1. Stratifying the data to identify health disparities
2. Assess quality of care
3. Plan for sharing the data with stakeholders
4. Plan to use performance measure data to inform quality improvement activities
5. Drill down to target interventions, identify improvement opportunities, and monitor compliance
6. Comparison against nationally recognized practice guidelines, outcome standards, or established baselines and benchmarks

Sampling

Sampling may be used as a method to measure data as a representation of the whole population of interest by collecting data on a sample of the population. A random methodology for sampling is established and each medical record should have an equal chance of being included in the sample. Sample size depends on the size of the client population being sampled and on the number, and complexity of the variables being reviewed. See Appendix E for Sample Size Table.

Quality Improvement

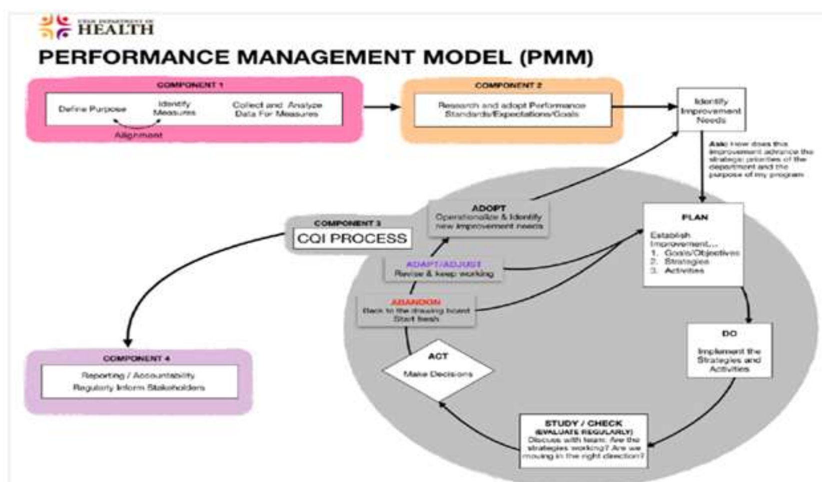
According to HRSA PCN 15/02, quality improvement entails the development and implementation of activities to make changes to the program in response to the performance data results. To do this, recipients are required to implement quality improvement activities aimed at improving patient care, health outcomes,

and patient satisfaction. The UDOH Performance Management Model describes the process for documentation of goals, objectives, strategies, and activities. These elements are tracked in the CQM work plan. QI project selection may be identified through quality assurance monitoring, benchmark comparison, individual and/or group survey/discussion.

QI Methodology

The PMM at the UDOH is a program-level method designed to engage staff in identifying their program purpose, understanding how to monitor performance, identifying opportunities for improvement, and using the CQI process to set goals, track progress toward goals, and report progress to stakeholders. PMM is founded on the following four primary components:

1. Program Purpose and Performance Measures
2. Performance Expectations, Standards, and Goals
3. CQI
4. Reporting and Accountability



Component 1: Program Purpose and Performance Measures

The purpose of the UDOH RWB Program is to provide core medical and support services to clients enrolled in the program. It aligns with the vision and mission of the department by assuring access to affordable quality health care and promoting healthy lifestyles so the people of Utah can enjoy the best health possible, where all can live and thrive in healthy and safe communities. Goals and quality improvement initiatives are focused on patient care, health outcomes and/or patient satisfaction.

Measures are identified that best indicate program achievements and accomplishments. Generally, fewer measures is better, as long as they indicate how well the program is achieving its purpose(s). Once a purpose and measures are agreed upon, the program is ready to identify and implement steps needed to collect and analyze data pertaining to the measure. Measures include quality throughput when possible. It is important to work closely with financial personnel to ensure a firm understanding of program financial aspects.

Component 2: Research and Adopt Performance Standards, Expectations, or Goals

It is essential to adopt performance standards, expectations, or goals so program members have a clear understanding of work expectations and what is to be accomplished in terms of quality, timeliness, outcomes, and volume, etc. Standards may come from regulatory or grant guidelines, leadership expectations, or set internally by the team. The HRSA, federal grant funder for the RWB program, strongly encourages the use of HRSA/HAB performance measures. UDOH RWB incorporates HRSA/HAB

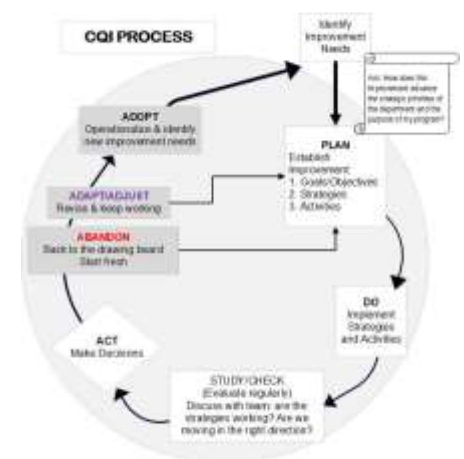
performance measures based on utilization outlined in PCN #15-02. See the section on Performance Measurement in this document for more details. Service Standards are established for each service category funded and follow guidelines in PCN #16-02.

Component 3: CQI Process

CQI is an ongoing effort using a deliberate and defined process such as the Plan, Do, Study, Act (PDSA) Cycle, focused on achieving measurable improvements. The UDOH promotes CQI, through a process founded upon the following principles:

1. Establishing an improvement plan that includes improvement goals, strategies, and activities
2. Implementing the plan
3. Evaluating and accounting for progress
4. Making informed decisions throughout the process

Improvement and sustainable change come from applied knowledge obtained from both quantitative and qualitative aspects. By using data and input from all team members, including UDOH RWB CQM Committee members, a clear understanding of areas that may need focused QI efforts are identified.



The program/team may ask, "*If every other area of our operation remained at its current level of performance, what is the one area where change would have the greatest impact*?" Upon asking this question, the program purpose, measures and standards created in Components 1 and 2 can be used to inform improvement activities in Component 3 of the PMM.

In the UDOH RWB program the aim is to improve the health of the community and/or increase capacity as efficiently as possible. QI results in achieving the program performance standards as outlined in Component 2 and/or agency strategic/funding priorities and existing goals which improve patient care, satisfaction, and health outcomes.

Efforts may focus on service, decreased process time, and/or effort, lower cost, etc. If several areas for improvement are identified the team prioritizes what is most important. Once a specific need for improvement is identified, a plan is developed, which includes goals, strategies, and activities designed to achieve the goal. The planning process can be equated to the plan step in the PDSA Cycle.

RWB encourages the use of a structured template to document and report systematic problem solving and quality improvement based on the principles of PDSA. The document is called an A3, which refers to a ledger size 11x17 piece of paper. This tool helps see the thinking behind the problem-solving. It is designed to use while working through the problem not after the problem is solved. The practice of using A3s forces project teams to focus efforts. They also make it easier for a leader or coach to review a problem solver's work. It provides feedback on the problem solving through process. See Appendix D for more information on the A3.

Improvement Effort: (name of the effort)
Sponsor/Sponsor Coalition: (supervisors/managers/executives sponsoring this effort)
Person(s) working on this: (person or team working on this improvement)

Date started: ____________
Current date ____________
Primary customer: *(who is the main end-use customer of the product/service from this process?)*

1 Reason for Improvement Succinct statement of what you want to improve, and why *(with background about the issue or opportunity)*	**4 Gap Analysis** Analysis of why there is a difference (gap) between boxes 2 (Initial State) and 3 (Target State) *(Use flowcharts, root cause analysis charts, etc. to display visually)*	**7 Complete Implementation** What is left to do to implement the Solution(s), after learning from your Rapid Experiments?
2 Initial State What does the initial state look like (including measurement of the current situation) *(Use graphs, charts, picture etc. to display visually)*	**5 Possible Solution(s)** Ways for closing that gap *(including an action plan for implementation and assignment of responsibility and accountability)*	**8 Evaluate Implementation** Current status of Implementation. And measuring and evaluating the results of what you implemented: did you close the gap (Initial State vs. Target State)?
3 Target State Where do you want / need to be, including a clear, measureable target *(Use graphs, charts, picture etc. to display visually)*	**6 Rapid Experiments / Pilots** Small-scale testing of Possible Solutions (if applicable) to close the gap	**9 Insight and Next Steps** Lessons learned and future opportunities

Quality Improvement Project Planning

QIPs may be identified by Program Administrators, Quality Management Team, or Community Partners.

1. Identifying Party communicates QIP to Quality Management Team.
2. Quality Management Team discusses QIP with appropriate Program Administrator(s) and seeks approval to move forward.
3. Quality Management Team coordinates QIP with "Identifying Party" and provides planning tools. For example, A3 framework/template.
4. Quality Management Team provides technical assistance, as needed, in developing documentation for QIP.
5. The Quality Management Team will oversee QIP implementation which includes:
   A. Facilitating documentation
   B. Monitoring progress through regular check in, data gathering, and/or tracking
   C. Providing technical assistance
   D. Reporting at the monthly Quality Management Team Meeting and the quarterly RWB CQM Committee Meeting
6. The QIP Team determines whether to adopt, adapt, or abandon QIP
   A. Adopt the interventions implemented to ensure ongoing accountability to maintain success of the project
   B. Adapt (adjust) make changes and continue the QIP cycle
   C. Abandon—not feasible or not needed
7. The Quality Management Team coordinates with QIP Team to present findings and results at the quarterly RWB CQM Committee Meeting (This may include a completed A3.)

Goals

The UDOH RWB CQM Committee defines goals, objectives, strategies, work plan, timeline, and accountability. Committee members then work within their individual organization to implement and complete improvement activities.

Goals are statements expressing desired outcomes or intended effects and are usually written in the form of "from X (current baseline) to Y (future goal) by when (future date)." A broad or complex goal may be written as an aspiration or intended effect on one or more problems, and may be stated without an "X" to "Y" and time limits. This type of goal usually needs objectives to address subcomponents of the goal because of its complexity. Simple and straightforward goals may not need objectives.

Example Improvement Goal: *Increase the percentage of RWHAP-B clients with viral suppression from a baseline of 88.9% in 2020 to 91% by December, 2021.*

Example Aspiration Goal: *Increase the number of RWHAP-B clients with viral suppression.*

Objectives

Objectives are used if the goal is stated as an aspiration. They are targets for achievement or solutions which will predictively influence the aspiration. They are time limited, measurable in all cases, and are written in the form of "from X (current baseline) to Y (future goal) by when (future date)." Objectives are specific, data driven, and evidence-based when possible.

Objective Example: *For RWB clients with a viral load greater than 200 copies, increase the percentage of documentation of review by an interdisciplinary team from an unknown baseline to 90% by December 2021.*

Strategies

A strategy is a clearly defined method, plan of action, or approach that, when properly executed, will predictively impact the objective or goal to which it relates. A strategy is most effective when it can be directly influenced by the program/team.

Example of Strategies: The HIV Care Continuum includes strategies to achieve viral suppression

1. Diagnosed with HIV
2. Linked to care
3. Engaged or retained in care
4. Prescribed antiretroviral therapy
5. Achieved viral suppression

Activities

After planning, the next step is to "Do" or implement the plan by completing activities. Activities are planned tasks, projects, or interventions implemented to carry out strategies. The program selects activities with the greatest potential impact on achieving the goal. It is important to select activities to which the entire team can contribute. Activity completion is tracked to demonstrate progress toward strategy implementation. Other items that may be tracked include: responsible person, due date, dependencies (activities that may need to be completed before a specific activity can be initiated), and customer satisfaction feedback loops. Both program and contracted service providers participate in the CQM Plan and activities.

Examples of Activities:

- Workshops
- Focus groups, committees, meetings
- Data drill down (see Appendix G)
- Educational curriculum and training
- Assessment and monitoring tools and reports
- Establishing collaborative partnerships
- Advocacy efforts
- Product development
- Improving and documenting processes
- Working with the media

Cadence of Accountability

Activities are assigned to members of the program/team and a cadence of accountability (COA) is established through which program/team members may account for completion (or progress) of these activities. During this phase, programs/teams collect and document data to track progress toward

completing activities, and achieving objectives and goals. It is important to "Study" results of activities to evaluate the impact of activities on desired outcomes.

A COA is a recurring cycle of short (20-30 minute) team meetings to account for past commitments on activities and make short-term commitments for new activities to be accomplished before the next meeting. This is the point in the CQI process where execution happens. During the accountability meeting, the team members:

1. Report on activities they committed to complete at the last meeting
2. Review the impact the activities have on the improvement goal(s) and/or strategies, and discuss successes and failures
3. Ask "Are the outcomes of the strategies and activities influencing our improvement goals and/or objectives?"
4. Discuss roadblocks and vow to clear the path
5. Commit to new activities they will complete before the next meeting

When committing to new activities, team members might ask, "What are the one or two most important things I can do before the next meeting to impact the goals/strategies?" or "What can we do this week to clear the path?" Each commitment must meet two standards:

1. The commitment must represent a specific deliverable.
2. The commitment must influence the goals or strategies.

A clear and simple way to display progress on improvement goals is to create a scoreboard. This display is visible and keeps the team informed of progress at all times to determine if the improvement is moving in the right direction. If progress is not captured, made visible, and updated regularly, the improvement goal can disappear. Team members tend to disengage when they do not know if progress is being made. High functioning teams always know if they are moving in the right direction.

Individuals are personally accountable to commitments they make.y. Management demonstrates support by authorizing team members to attend short but frequent accountability team meetings, and to complete commitments and activities.

The next step is "Act." This phase involves deciding actions based on results.

1. If the measurable goal/objective has been met **adopt** and standardize the improvement,
2. **Adapt**, adjust, or modify strategies or activities; or continue with an adjusted time frame.
3. If the changes made to the process did not result in an improvement **abandon** those changes, consider lessons learned from the process, and return to the plan phase. In some cases, the team may need to step back and look at the big picture and create a different plan.

Once the improvement goal is realized, the team identifies the next improvement priority and repeats the process. This ongoing cycle is the principle of "continuous" quality improvement. For more information about the PDSA Cycle, see Appendix F.

Component 4 Reporting and Accountability

Methods of regular reporting to managers, staff, policymakers, stakeholders, and constituents is implemented. Consider what different audiences need to be kept informed. Report in a way that enables a program to consistently account for improvement activities in regular intervals. Often, the information reported to these audiences is summary data. This may be accomplished through a dashboard that links performance reports to the appropriate audience. See Appendix C for Quality Improvement Measures and Reporting.

Work Plan

The work plan or action plan, provides an overview of goals, objectives, strategies, activities, implementation timelines, milestones, and accountability for all CQM program activities outlined in the CQM Plan. The work plan is developed, shared, and communicated with the CQM Committee and other appropriate internal and external stakeholders, leadership, and clients. See Appendix B for current Quality Management Work Plan.

Evaluation

The CQM program evaluation follows HRSA guidelines, policy, and the CQM Plan Checklist. The effectiveness of the work plan and performance measure results are included in the evaluation. The plan is evaluated for completeness by the quality coordinator using the HRSA CQM plan Checklist. Any suggestions or deficiencies are noted on the checklist form. The RN Clinical Quality Consultant is responsible to review the evaluation and make appropriate adjustments. This is submitted to RWB leadership. Performance measures are evaluated quarterly by the UDOH RWB program quality staff and at the CQM Committee meeting.

Sustainability

Strategies may be adapted based on performance measures, feedback from the CQM Committee, and the assessment and evaluation results. Ongoing staff and client training and communication for a culture of CQI ensures the best care and outcomes for our clients and the community.

Review Routing

Date	Reviewer Title	Description of change and location in document
12/31/2020	Quality Coordinator	Applied consistent formatting to Acknowledgements section and alphabetized Glossary. Very minor grammatical edits throughout. Aligned Appendix B Work Plan with Quality Improvement Goals section.
3/4/2021	Quality Consultant	Applied suggestions from review team, updated workplan
1/14/2021	ADAP Admin	
2/08/2021	Part B Admin	Added Oral health and Transportation in the section dedicating staffing under Part B Admin
		Added the due date for Appendix B under the Client Satisfaction survey

APPENDICES

Appendix A: Resources

Appendix B: Quality Management Work Plan

Appendix C: QI Measurement Monitoring and Reporting

Appendix D: A3

Appendix E: Sample Size

Appendix F: PDSA Model

APPENDIX A: Resources

- AIDS Education and Training Centers (AETC)
- Centers for Disease Control and Prevention: www.cdc.gov
- Clinical Guidelines for the Treatment of HIV/AIDS
- Guide for HIV/AIDS Clinical Care, 2014 (PDF - 6 MB)
- HAB National Monitoring Standards Ryan White Part B Grantees Section D: Quality Management
- HAB Performance Measure Portfolio
- Health and Adherence-related Clinical Quality Management (CQM): Considerations for ADAP
- HIV Care Continuum
- HIV/AIDS Treatment Information Service (DHHS Treatment Guidelines): www.hivatis.org
- https://www.hiv.gov/federal-response/national-hiv-aids-strategy/overview
- HIV Prevention with Adults and Adolescents with HIV in the United States http://www.cdc.gov/hiv/prevention/programs/pwp/index.html
- HIVQM Instruction Manual 2016
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013 downloaded 5/2/2018 from: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA Health Resources & Services Administration: https://www.hrsa.gov/
- HRSA TARGET Center – technical assistance for the Ryan White community:
- NASTAD RWHAP-B Service Standards
- National Guideline Clearinghouse: http://www.guideline.gov/
- PDSA Model: http://asq.org/learn-about-quality/project-planning-tools/overview/pdca-cycle.html
- PDSA How to Improve: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx
- Policy Clarification Notice #15-02: https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/clinicalqualitymanagementpcn.pdf
- Policy Clarification Notice (PCN) 16-02
- U.S. Department of Health & Human Services HHS.gov https://www.hhs.gov/opa/reproductive-health/fact-sheets/sexually-transmitted-diseases/hiv/index.html

APPENDIX B: Quality Management Work Plan

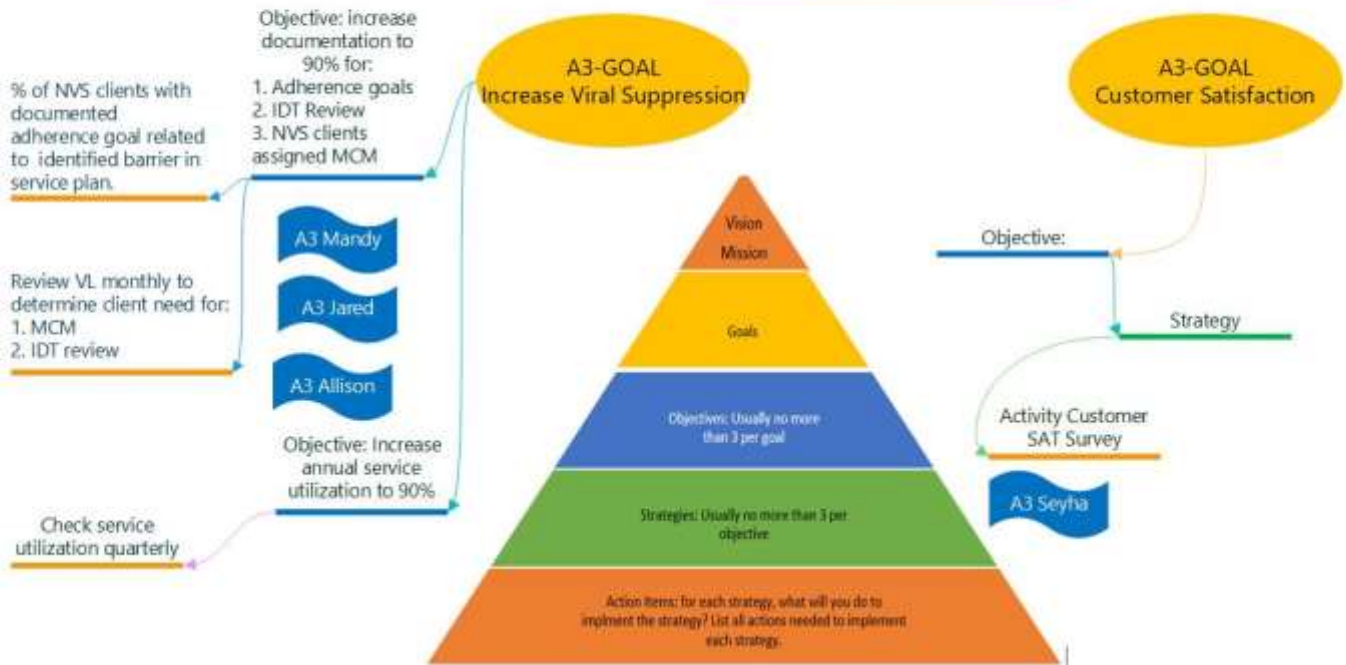
The work plan summarizes quality management program activities outlined in the quality management plan. The work plan is developed, shared, and communicated with the UDOH RWB CQM Committee and other appropriate internal and external stakeholders, leadership, and clients. The UDOH RWB CQM Committee defines goals, objectives, strategies, work plan, timeline, and accountability. Committee members then work within their individual organization to implement and complete improvement activities.

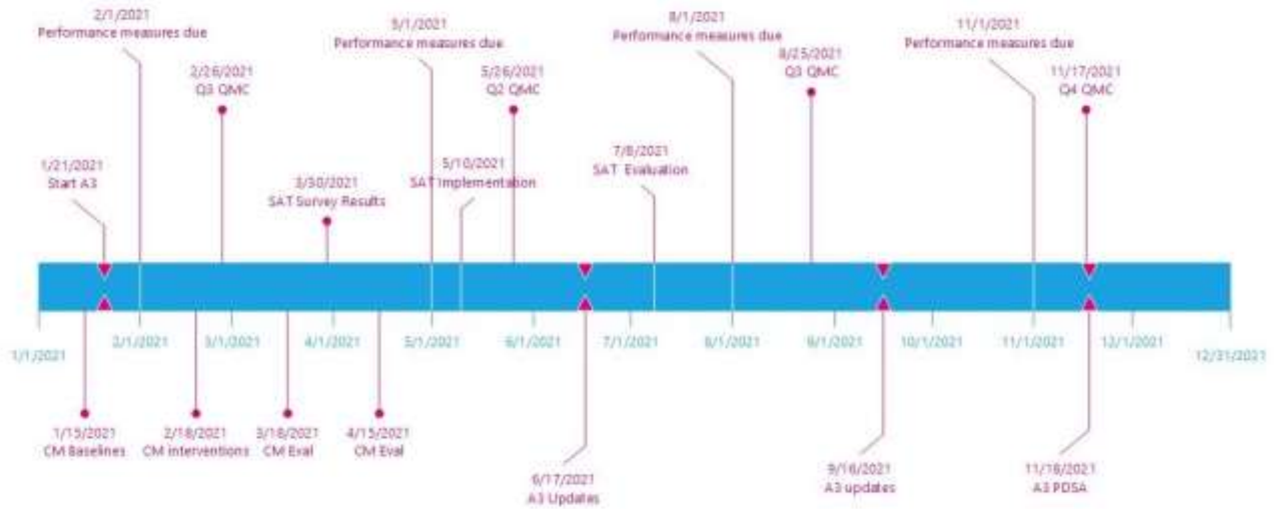
UDOH RYAN WHITE PART B QUALITY MANAGEMENT WORK PLAN 2021

<table>
<tr><td colspan="4">Goal 1: Increase viral suppression rate for all Ryan White B Clients from a 2020 baseline of 88.9% to 91% by December 2021</td></tr>
<tr><td colspan="4">Objective A. By December 2021, for clients with a viral load greater than 200 copies, increase the percentage of documentation in the client record to 90% for clients:
• Assigned MCM
• Review by an interdisciplinary team
• Identified adherence barriers
• Treatment adherence goal to address identified adherence barriers in the MCM service plan</td></tr>
<tr><td colspan="4">Objective B. Increase RWB enrolled clients’ annual service utilization from an October 2019–September 2020 baseline of 87% to 90% by December 2021</td></tr>
<tr><th>Activity</th><th>Responsible Person(s)</th><th>Due</th><th>Status</th></tr>
<tr><td>1. Review and revise the CQM Plan annually using the HRSA checklist to ensure completeness</td><td>Clinical Quality Consultant (CQC)
Quality Coordinator (QC)</td><td>Mar 2021</td><td>In progress</td></tr>
<tr><td>2. Complete annual CQM Program evaluation</td><td>CQC/QC</td><td>Aug 2021</td><td>In progress</td></tr>
<tr><td>3. Quality Improvement Projects</td><td>CQC/QC</td><td>Feb 2021</td><td>Identified</td></tr>
<tr><td>A. QI Rapid</td><td>IDC, CQC</td><td>Dec 2021</td><td>In progress</td></tr>
<tr><td>B. QI Medical Case Management</td><td>IDC, CQC</td><td>Dec 2021</td><td>In progress</td></tr>
<tr><td>4. CQM meetings</td><td>CQC</td><td>Quarterly</td><td>In progress</td></tr>
</table>

<table>
<tr><td colspan="4">Goal 2: Establish a process to regularly assess and improve RWB customer satisfaction by December 2021</td></tr>
<tr><td colspan="4">Objective: Assess Ryan White B Client (customer) satisfaction, implement, and evaluate one or more improvements as a result of the satisfaction assessment by December 2021</td></tr>
<tr><th>Activity</th><th>Responsible Person(s)</th><th>Due</th><th>Status</th></tr>
<tr><td>Client Satisfaction Survey</td><td>CAC, Part B Administrator, QC</td><td>Apr 2021</td><td>In progress</td></tr>
</table>

WORK PLAN by Dec 2021
Viral Suppression





APPENDIX C: Quality Improvement, Measures, Monitoring, Reporting

The subrecipient:

A. Participates in HRSA required Performance Measurement (PM)
   1. Assists with determining required PM(s)
   2. Conducts monitoring and data collection for PM(s) as set by the UDOH and Clinical Quality Management (CQM) Committee
   3. Submits PM(s) reports to the UDOH as set by the (CQM) Committee.

2021 Required Performance Measurement (includes 100% enrolled RWB clients)				
Quarterly	Q1	Q2	Q3	Q4
Measurement Period	Apr 2020–Mar 2021	Jul 2020–un 2021	Oct 2020-Sep 2021	Jan 2021 -c 2021
Subrecipient submits quarterly PM Report to DEPARTMENT by:	May 1, 2021	Aug 1, 2021	Nov 1, 2021	Feb 1, 2022

B. Participates in Quality Assurance (QA) activities
   1. Assists with determining QA measures.
   2. Conducts QA monitoring and data collection

C. Participates in Quality Improvement (QI) activities as set by the DEPARTMENT and CQM Committee.
   1. Assists with determining QI goal(s), objectives and/or activities
   2. Conducts QI activities as set by the DEPARTMENT and CQM Committee
   3. Submits quarterly QI Activity Report to the CQM Committee

APPENDIX D: A3

Improvement Effort: (name of the effort)
Sponsor/Sponsor Coalition: (supervisors/managers/executives sponsoring this effort)
Person(s) working on this: (person or team working on this improvement)

Date started: ____________
Current date ____________
Primary customer: *(who is the main end-use customer of the product/service from this process?)*

PLAN

1 Reason for Improvement	4 Gap Analysis	7 Complete Implementation
Succinct statement of what you want to improve, and why *(with background about the issue or opportunity)*	Analysis of why there is a difference (gap) between boxes 2 (Initial State) and 3 (Target State) *(Use flowcharts, root cause analysis charts, etc. to display visually)*	What is left to do to implement the Solution(s), after learning from your Rapid Experiments? **DO**
2 Initial State	**5 Possible Solution(s)**	**8 Evaluate Implementation**
What does the initial state look like (including measurement of the current situation) *(Use graphs, charts, picture etc. to display visually)*	Ways for closing that gap *(including an action plan for implementation and assignment of responsibility and accountability)*	Current status of Implementation. And measuring and evaluating the results of what you implemented: did you close the gap (Initial State vs. Target State)? **STUDY**
3 Target State	**6 Rapid Experiments / Pilots**	**9 Insight and Next Steps**
Where do you want / need to be, including a clear, measureable target *(Use graphs, charts, picture etc. to display visually)*	Small-scale testing of Possible Solutions (if applicable) to close the gap **DO**	Lessons learned and future opportunities **ACT**

Improvement Title: ____
Program:____________________________________
Person(s) working on this: ________________________________

Start Date: ____________
Current Date ____________
Primary Customer: __________

1 Reason for Improvement	4 Gap Analysis	7 Complete Implementation
2 Initial State	**5 Possible Solutions**	**8 Evaluate Implementation**
3 Target State (X to Z by Y)	**6 Rapid Experiments / Pilots**	**9 Insight and Next Steps**

APPENDIX E: Sample Size

The sample size chart is used to determine a minimum number of clients needed to represent the population of interest. It may be used by subrecipients for quality assurance monitoring or other purposes.

a) For the monitoring period, determine the number of clients who received the service of interest (e.g., MCM)

b) Use the number of clients served to decide the minimum number of records needed from the HIVQUAL Sample Size Chart

c) Determine the number of new clients and subtract this from the total needed (all new clients are monitored)

d) Using SAS 9.4 generate random sample of current clients, weighted by gender

HIVQUAL Sample Size Chart

This chart is based on a 90% confidence interval with an error width of 16% when using the minimum number of records.

TOTAL SAMPLE TABLE		
TOTAL ELIGIBLE POPULATION	MINIMUM TOTAL RECORDS	CHARTS TO PULL
Up to 20	All	All
21 - 30	24	31
31 - 40	30	39
41 - 50	35	46
51 - 60	39	51
61 - 70	43	56
71 - 80	46	60
81 - 90	49	64
91 - 100	52	68
101 - 119	57	74
120 - 139	61	79
140 - 159	64	83
160 - 179	67	87
180 - 199	70	91
200 - 249	75	98
250 - 299	79	103
300 - 349	82	107
350 - 399	85	111
400 - 449	87	113
450 - 499	88	114
500 - 749	94	122
750 - 999	97	126
1000 - 4999	105	137
5000 or more	107	139

FEMALE SAMPLE TABLE		
TOTAL ELIGIBLE FEMALES	MINIMUM FEMALE RECORDS	CHARTS TO PULL
Up to 20	All	All
21 - 30	24	31
31 - 40	30	39
41 - 50	35	46
51 - 60	39	51
61 - 70	43	56
71 - 80	46	60
81 - 90	49	64
91 - 100	52	68
101 - 119	57	74
120 - 139	61	79
140 - 159	64	83
160 - 179	67	87
180 - 199	70	91
200 - 249	75	98
250 - 299	79	103
300 - 349	82	107
350 - 399	85	111
400 - 449	87	113
450 - 499	88	114
500 - 749	94	122
750 - 999	97	126
1000 - 4999	105	137
5000 or more	107	139

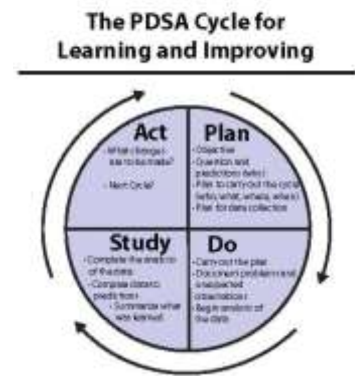
APPENDIX F: PDSA Model

The ABCs of PDSA Grace Gorenflo and John W. Moran

Plan: The purpose of this phase is to investigate the current situation, fully understand the nature of any problem to be solved, and to develop potential solutions to the problem that will be tested.

1. **Identify and prioritize quality improvement opportunities**. Usually a team will find there are several problems, or quality improvement opportunities, that arise when programs or processes are investigated. A prioritization matrix may help in determining which one to select. Once the quality improvement opportunity has been decided, articulate a problem statement. Revisit and, as appropriate, revise the problem statement as you move through the planning process.
2. **Develop an AIM statement** that answers the following questions:
    a. What are you seeking to accomplish?
    b. Who is the target population?
    c. What is the specific, numeric measure(s) you are seeking to achieve?
    d. The measurable improvement objective is a key component of the entire quality improvement process. It's critical to quantify the improvement you are seeking to achieve. Moreover, the entire aim statement also will need to be revisited and refined as you move through the planning phase.
3. **Describe the current process** surrounding the problem in order to understand the process and identify areas for improvements. Flow charts and value stream mapping are two examples of methods to accomplish this.
4. **Collect data on the current process**. Baseline data that describe the current state are critical to further understanding the process and establishing a foundation for measuring improvements. The data may address, for example, time, people, space, cost, number of steps, adverse events, and customer satisfaction. A host of tools are available to collect and interpret data on the process, such as Pareto charts, histograms, run charts, scatter plots, and control charts. The data collected must be aligned with the measures listed in the aim statement.
5. **Identify all possible causes** of the problem and determine the root cause. While numerous causes will emerge when examining the quality improvement opportunity, it is critical to delve in and carefully identify the underlying, or root, cause of the problem, in order to ensure an improvement or intervention with the greatest chance of success is selected. Brainstorming is a useful way to identify possible causes and a cause and effect/fishbone diagram and the 5 Whys are useful for determining the actual root cause.
6. **Identify potential improvements** to address the root cause, and agree on which one to test. Once the improvement has been determined, carefully consider any unintended consequences that may emerge as a result of implementing the improvement. This step provides an opportunity to alter the improvement and/or develop countermeasures as needed to address any potential unintended consequences. Revisiting the aim statement and revising the measurable improvement objectives are important steps at this point.
7. **Develop an improvement theory**. An improvement theory is a statement that articulates the effect you expect the improvement to have on the problem. Writing an improvement theory crystallizes what you expect to achieve as a result of your intervention, and documents the connection between the improvement you plan to test and the measurable improvement objective.
8. **Develop an action plan** indicating what needs to be done, who is responsible, and when it should be completed. The details of this plan should include all aspects of the method to test the improvements, what data will be collected, how frequently data are collected, who collects the data, how they are documented, the timeline, and how results will be analyzed.

Do: The purpose of this phase is to implement the action plan.



1. Implement the improvement
2. Collect and document the data
3. Document problems, unexpected observations, lessons learned and knowledge gained

Study: This phase involves analyzing the effect of the intervention. Compare the new data to the baseline data to determine whether an improvement was achieved and whether the measures in the aim statement were met. Pareto charts, histograms, run charts, scatter plots, control charts and radar charts are all tools that can assist with this analysis.

1. Reflect on the analysis, and also consider any additional information that emerged. Compare the results of your test against the measurable objective.
2. Document lessons learned, knowledge gained, and any surprising results that emerged.

Act: This phase marks the culmination of the planning, testing, and analysis regarding whether the desired improvement was achieved as articulated in the aim statement. The purpose is to act upon what has been learned. Options include:

1. **Adopt**: Standardize the improvement if the measurable objective in the aim statement has been met. This involves establishing a mechanism for those performing the new process to measure and monitor benchmarks on a regular basis to ensure improvements are maintained. Run charts or control charts are two examples of tools to monitor performance.
2. **Adapt**: The team may decide to repeat the test, gather different data, revise the intervention, or otherwise adjust the test methodology. This might occur, for example, if sufficient data weren't gathered, circumstances have changed (e.g., staffing, resources, policy, environment, etc.), or if the test results fell somewhat short of the measurable improvement goal. In this case, adapt the action plan as needed and repeat the "Do" phase.
3. **Abandon**: If the changes made to the process did not result in an improvement, consider lessons learned from the initial test, and return to the "Plan" phase. At this point the team might revisit potential solutions that were not initially selected, or delve back into a root cause analysis to see if additional underlying causes can be uncovered, or even reconsider the aim statement to see if it's realistic. Whatever the starting point, the team will then need to engage in the Plan cycle to develop a new action plan, and move through the remaining phases.

PDSA offers a data-based framework based on the scientific method. This simple, yet powerful format drives continuous and ongoing efforts to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.