Heart of Florida United Way
Area 7

Quality Improvement Tool Kit

GY 2025 - 2026

Ryan White Part B & General Revenue

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Section 1

Quality Management Overview

Quality Management is a required component in all healthcare settings where outcomes are measured to ensure that services are delivered in a consistent manner, promoting the overall health and wellness of the clients being served.

With respect to the Ryan White HIV/AIDS Program, Quality Management consists of various activities that ensure HIV managed care services are delivered to Ryan White clients in a manner consistent with current professional health standards. Quality Management offers a framework for service delivery to be continually improved based on the collection and analysis of outcome driven data.

It is important to recognize the differences between Quality Improvement and Quality Assurance under the umbrella of Quality Management. Often times these two phrases are used interchangeably however, they have differing scopes and applications.

Quality Assurance

VS

Quality Improvement

The main objective for Quality Assurance (QA) is to measure a system's compliance with established standards and is the responsibility of specific and designated staff. This is a required and reactive component focusing on identifying the outliers or 'bad apples' in a given sample.

Examples of QA include, but are not limited to, Chart Review, Peer Review, and Audits

The main objective for Quality Improvement (QI) is to continually improve a process to improve healthcare outcomes and is the responsibility of all staff members. This is a chosen and proactive approach which focuses on processes and systems which impact a client's healthcare outcomes.

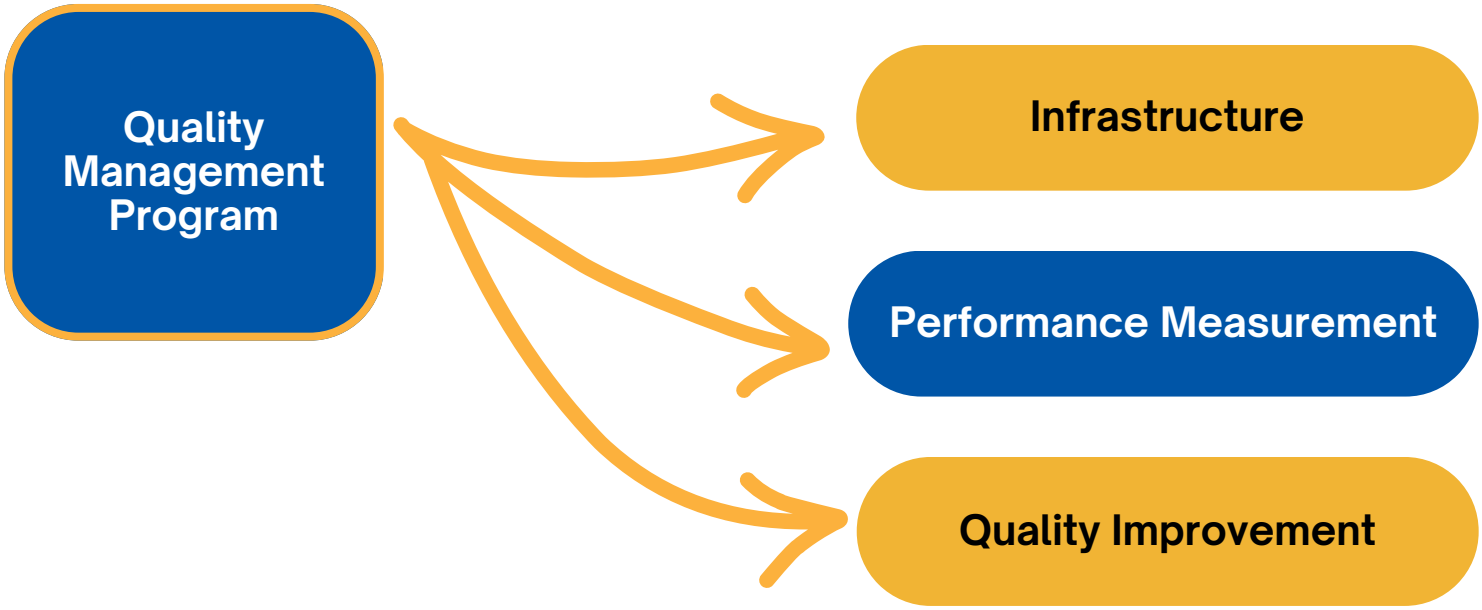
Examples of QI include, but are not limited to, PDSA Cycles and Pilot Testing.

Section 2

HRSA Requirements

The Health Resources Services Administration (HRSA) outlines all the required elements of a Clinical Quality Management program for all program parts in Policy Clarification Notice 15-02, commonly referred to as PCN 15-02. This guiding document outlines required components of an effective CQM program for all subrecipients receiving Ryan White Funding. Provider's CQM programs are assessed for elements of all of the required components annually with the submission of their CQM Plan to the Lead Agency.

These required elements outlined in PCN 15-02 for a successful CQM program that improves patient care, health outcomes and patient satisfaction are as follows:



Agency Level Quality Management Committees should annually assess their program utilizing the Organizational Assessment Tool. This tool will help the committee to identify opportunities for improving their program year over year. A copy of the Part B Organizational Assessment is contained in Section 9 of this tool kit.

The agency's Quality Management Plan should clearly demonstrate these three elements. The plan should also articulate:

- Specific aims based in health outcomes
- Support by identified leadership
- Accountability for CQM activities
- Dedicated resources
- Use of data and measurable outcomes to determine progress and make improvements to achieve the specified aims

Section 3

Quality Management Infrastructure

HRSA Policy Clarification Notice 15-02 outlines the requirements for a successful Quality Management program. Below are each of the identified infrastructure components.

Agency Leadership

Agency Leadership should be dedicated to overall quality improvement. The Quality Management Program itself should have dedicated leadership who is responsible for QM activities; this individual is often referred to as a Quality Coordinator or Quality Manager. Quality improvement should also be supported by stakeholders in the agency or organization.

Dedicated Resources

The agency or organization should dedicate adequate resources to quality improvement efforts undertaken by the quality management team. Resources include but are not limited to, data collection tools, analysis software, and training resources specific to quality management.

Quality Management Plan

A written Quality Management Plan is required that outlines the program's goals, it's structure and the methods deployed to monitor and improve quality throughout the agency. This written plan should include timelines, responsibilities, and how the activities align with the agency's goals

Performance Measurement

The agency should develop measurement indicators to assess key areas of HIV care and services; these indicators should align with local, state and national goals. Data should be regularly collected and assessed to identify trends, strengths and opportunities for improvement.

Quality Improvement Activities

The agency or organization should implement Quality Improvement activities or initiatives to address any opportunities for improvement or identified gaps in care or services.

Consumer & Stakeholder Involvement

There should always be people with HIV and other stakeholders involved in the planning, implementation and evaluation of the Quality Management program. Feedback offered by PWH and stakeholders should be incorporated to ensure services are client centered.

Evaluation & Reassessment

Periodic review and updates to the QM plan and program should be based on quality improvement activity outcomes and changing client needs. Improvements should always be aligned with best practices and the goal of enhancing care.

Section 4

Performance Measurement

Performance Measurement is the process of collecting, analyzing, and reporting data regarding client care, health outcomes on an individual or population level, and patient satisfaction. All recipients and subrecipients are encouraged to use the National HIV/AIDS Strategy (NAS 2020) to frame all CQM activities and goals.

A frequent question that arises is, "How many performance measures should our agency be following?" The answer to this depends entirely on the overall utilization of each funded service at your agency. We will use your agency's annual Ryan White Services Report (RSR) to identify which services require performance measures and how many measures are required based on overall utilization. The table below illustrates HRSA's expectations for the number of performance measures required:

Percent of RWHAP eligible clients receiving at least one unit of service for a RWHAP-funded service category	Minimum number of Performance Measures
>= 50%	2
>15% to <50%	1
<=15%	0

- **If at least 50% or more of clients utilize a specific RWHAP-funded service at your agency, then you are required to have two (2) performance measures for that service category that are monitored by your quality management plan.**
- **If at least 15% but less than 50% of clients utilize a specific RWHAP-funded service at your agency, then you are required to have one (1) performance measure for that service category that is monitored by your quality management plan**
- **If less than 15% of client utilize a specific RWHAP-funded service at your agency, then you are not required to have a performance measure for this service category**

Performance measures can and should include: Indicators established by the HIV/AIDS Bureau, HIV Care Continuum indicators, and Health and Human Services Outcomes and Indicators.

At a minimum, data collection for quality management performance measures should occur quarterly.

The Area 7 Lead Agency has decided to monitor QM Performance measures monthly.

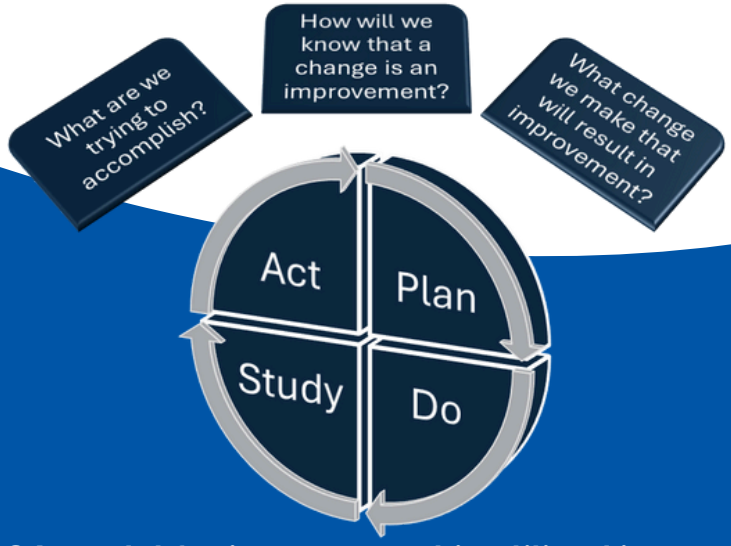
Performance Measures should also focus on the priority populations identified by the National HIV/AIDS Strategy:

- Gay, bisexual and other men who have sex with men, in particular Black, Latino and American Indian/Alaksa Native Men
- Black women
- Transgender women
- Youth aged 13-24 years
- People who inject drugs

Section 5

The Model for Improvement: Plan - Do - Study - Act

There are many different models for improvement that are used throughout quality management programs but for the purposes of this toolkit we are going to focus on utilizing the **Plan - Do - Study - Act** or **PDSA** model of improvement.



The PDSA model for improvement is utilized in a multitude of different healthcare settings by quality management teams in order to continually assess and improve their patient's healthcare outcomes. It is a relatively simple and extremely versatile model that is designed to be scaled up to meet the needs of any sized patient care system.

Steps to Developing a PDSA Cycle

Step 1: Create your AIM Statement

Your aim statement should answer the question of what you hope to accomplish with the project and should be SMART (Specific, Measurable, Achievable, Realistic and Timebound).

Step 2: Establishing Measures

Measures can be outcome-based, process-based or balancing. It is important to remember that baseline data is needed to document improvement. Try to establish your measure using a numerator and denominator.

Step 3: Selecting Changes

What changes can be made that will result in improvement for the system? It is vital to take into consideration the views of those who work and receive care within the system you're attempting to change.

Step 4: Testing Changes

Initiate your first PDSA cycle, remembering to start small and scale your test up according to your results.

Developing an AIM Statement

Before you are able to draft the AIM statement for your QI project, you should first be able to clearly identify and articulate what the problem is that you're hoping to solve with your PDSA cycle / QI Project. Your first step to drafting your AIM statement will be to draft your **problem statement.**

The following questions will help your QI team accurately frame the problem that you are hoping to address:

- Why are we doing this project?
- What is the problem we are wanting to address?
- Who is affected and why does it matter?
- How does it affect the patient/client?

Try to align your project with one of the six dimensions of quality established by the Institute of Medicine: safe, effective, patient-centered, timely, efficient, and equitable (National Academies Press, 2001)

Once your QI Team identifies a problem, it is time to draft your AIM Statement. It is important to keep in mind that your AIM statement should always be **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**imebound, commonly abbreviated as **SMART**. Your AIM statement should be directed towards improving either a process or an outcome. It is vital that your QI team knows what the baseline measurement is for the process or outcome that you are attempting to change.

You can use the below AIM Frame to help you when your team is ready to draft your own AIM statement.

AIM Statement

To (increase or decrease) _____(identify process or outcome)_____
from _____(base line percentage, rate, number, or other quantitative value_____
to _____goal or target percentage, rate, number or other quantitative value_____
by _____specify a specific date you want this change to occur_____
in _____(identify the population impacted by this change)_____

Example:

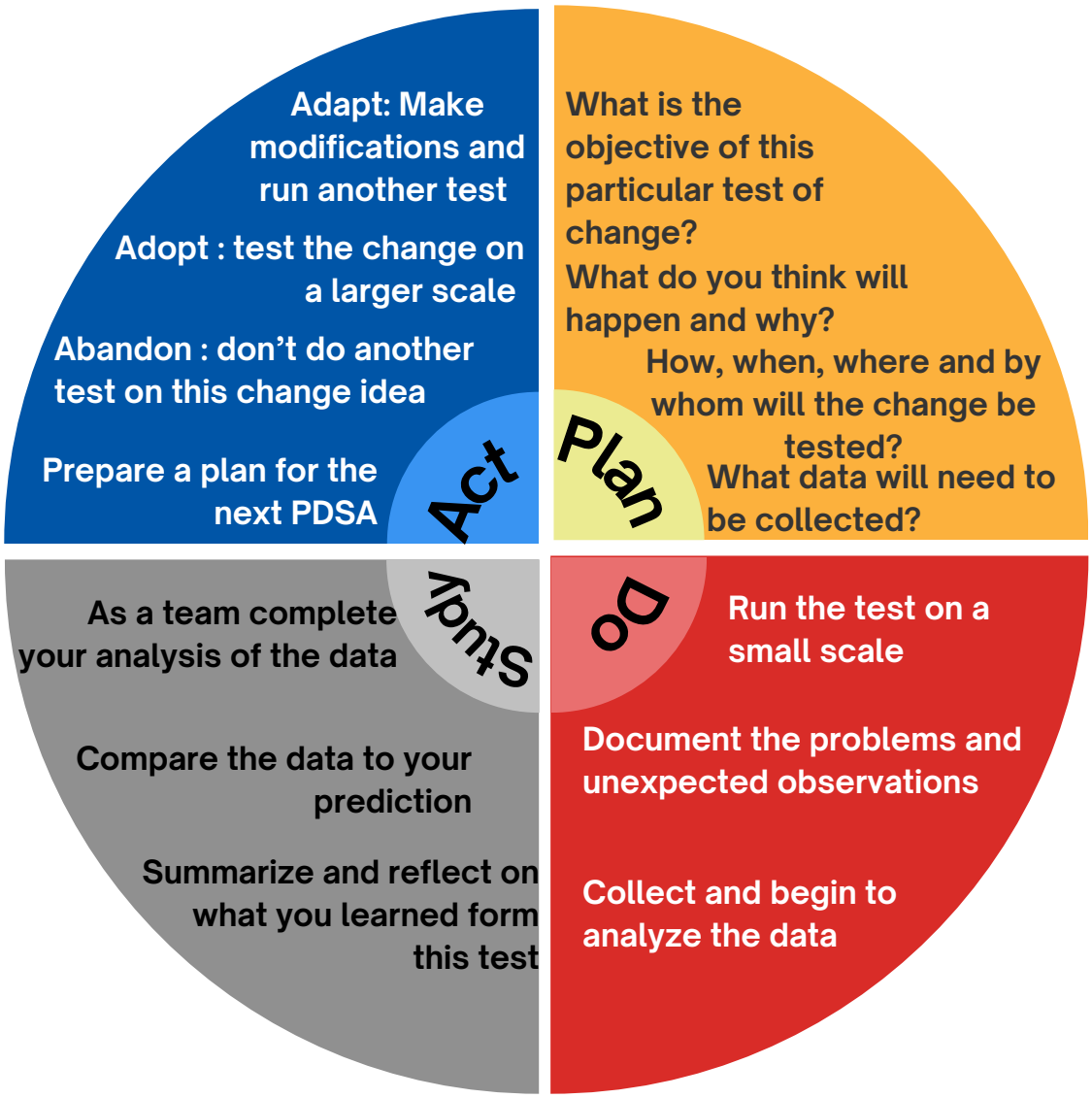
To increase viral load suppression from 87.2% to 91% by March 31st 2025 in Latino male clients.

Institute of Medicine (US) Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington (DC): National Academies Press (US); 2001.

Deploying your PDSA Cycle

Now that you have taken the steps to create an AIM statement, define your measures, and identified the change you wish to see within the system, it is time to put your theory into practice and test your change.

Each one of the distinct steps in the Plan-Do-Study-Act process have guidance for QM teams to follow when utilizing this model for improvement. The graphic below will outline the different guidance for each of the 4 steps in this process.



PDSA Cycles and the Rule of 1

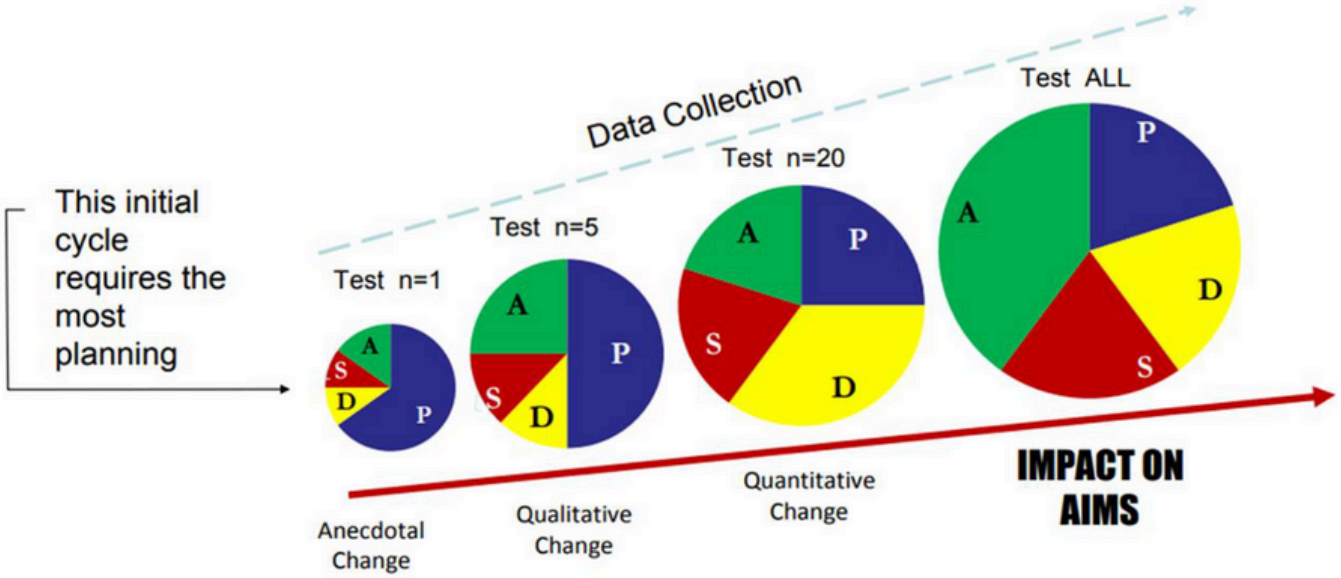
For your first PDSA cycle you are going to want to start off small in your design scope, timeframe and sample size. Look at what change you can make in ***one*** week, with ***one*** provider, at ***one*** facility with ***one*** patient.

Collect and analyze the results of this small change and then prepare to scale up your test to incorporate a wider timeframe and sample size.

Ramp Up Your PDSA Cycles

As you begin to get data on what works and what doesn't work, taking into account any unexpected outcomes from initial tests, you can then begin to scale up your PDSA cycles to include a greater sample size. You can see in the graph below that the most amount of time spent planning goes into that first cycle, with each successive cycle building on the successes and failures of the previous ones.

It is important to remember that failures are 100% okay when it comes to testing changes. Failures allow you to identify variables that don't work to achieve your aim. Oftentimes through failures, you are able to identify unexpected correlations between variables that you hadn't previously considered. When you encounter failure, it's important to not give up entirely, even though it is human nature to want to scrap everything attached to the failure and start over. Rather than restarting, making modifications to your already established processes often yields more promising outcomes, especially when you are implementing cycles with larger sample sizes .



Tips for Effective PDSA Cycles

- **In the beginning, Test on a Small Scale**
- **Scale Down the Time Frame**
  - Take the suggested time frame and scale down two
- **Use Volunteers to Test your Early PDSA Cycles**
  - Use volunteers interested in doing things differently to help get the data needed to win over skeptics
- **Do Not Treat QI as Scientific Research**
  - It's a test not a clinical trial, you don't need double-blind data you just need information on how things work.
- **Meet Regularly with Your QI Team**
  - Grab people when you can and share information when it is available

Section 6

Quality Management Plan

Your agency's quality management plan will be a living document that exists to guide the efforts and actions of the quality management team. This document has multiple parts and is something that is updated on a routine basis, usually as dictated by your agency's quality committee.

Below will outline some of the elements that should be present in your agency's quality management plan:

Statements

The following statements should be clearly articulated in your quality management plan:

- **Purpose Statement :** Defines the purpose of the QM program and how it aligns with the agency's mission
- **Mission Statement :** Describes how the activities of the QM team support improved health outcomes for your agency's clients
- **Quality Statement :** This is a concise statement which reflects the agency's commitment to delivering high-quality, client-centered and equitable HIV care

Leadership & Governance

This section should clearly identify the different Quality Management leadership roles which should include a designated Quality Manager and Quality Team. These roles should be clearly defined and have their responsibilities outlined. A detailed description of how stakeholders are involved in the agency's quality management activities as well as clearly outlines how the agency's leadership supports and drives quality initiatives.

Goals, Objectives & Scope

The Quality Management Plan should clearly define the services and populations that are covered by the plan (i.e. Outpatient Ambulatory Health, Medical Case Management, etc). The goals created for these covered populations should be aimed at improving access, retention, adherence and outcomes. The overall objective should always be aligned with local, state and national HIV/AIDS goals and priorities

Performance Measurement

The Quality Management plan should clearly identify specific and measurable quality indicators and the process for collecting, analyzing and reporting this performance data. Baselines and benchmarks should always be included for comparison.

Data Collection & Analysis

There should be a clear description of the data sources that will be used such as electronic health management records, CAREWare, or client surveys. You should also outline how this data will be collected and analyzed and include how and when reporting of this daya will take place within your agency.

Quality Improvement Activities

The agency's Quality Management plan should clearly decrible the improvement methodology that will be used to effect change and the process by which the QM team will identify gaps in care or services. There should be documentation of the outcomes and lessons learned from the most recent improvement projects undertaken by the quality team.

Consumer Involvement

Your quality management plan should articulate how the quality improvement team will ensure involvement of people with HIV in its activities as well as how consumer feedback will be integrated into any efforts undertaken by the team

Training & Communication

Plans should have clearly articulated plans for ongoing staff training in QM and QI subject matters and include capacity building initiatives to improve staff's skill in quality improvement. The QM Plan should also outline the various methods by which QM activities will be shared with the staff, consumers and stakeholders. Examples could include the use of monthly newsletters, regular meetings or dashboards.

Evaluation, Sustainability & Timeline

The Quality Management plan should outline a process for how evaluating the effectiveness of the program as well as list the programs proposed strategies for sustaining quality improvement and for adapting to ever changing needs and priorities.

The QM plan should also have clearly articulated timelines for implementation of the QM plan activities. The schedule should include regular updates based on progress, changes or new goals

Approval & Accountability

The Plan's approval processes should be clearly documented within the plan indicating that the agency's leadership and stakeholders have reviewed and are in approval and agreement of the proposed quality improvement activities to take place.

The plan should clearly assign accountability to an individual or group of individuals for monitoring the implementation and success of the QM program.

The QM Plan helps to ensure that the agency delivers high-quality, equitable, and client-centered services while fostering an organizational culture of continuous improvement and compliance with acceptable healthcare standards. Subrecipient QM plans are reviewed on an annual basis utilizing the Clinical Quality Management Plan Review Checklist. The CQM Plan Review Checklist is a standardized tool to ensure that all elements of a CQM program outlined in the PCN 15-02 are present in the subrecipient's clinical quality management plan. ***A copy of this check list can be found in the Appendix of this toolkit.***

Section 7 Organizational Assessment Tool

The Organizational Assessment (OA) Tool offers quality management committees and agency leadership a standardized methodology for assessing their quality management program. This tool is typically deployed annually to assess the current state of a quality management program and identify opportunities for improvement. The RWHAP Part B program utilizes the 2017 version of the Organizational Assessment Tool and requires subrecipients to complete and submit this tool by the end of February, prior to the new grant year starting in April. ***A copy of this tool can be found in the Appendix of this Tool Kit.***

Area 7 subrecipients are encouraged to use the National Quality Center Organizational Assessment Tool for Ryan White HIV/AIDS Program-funded Programs June 2017 version to promote consistency among all funded providers in the program area. This document is offered to subrecipients in a Microsoft Word editable format as well as an editable PDF format.

This tool separates overall clinical quality management into specific areas and categorizes progress by numerically categorizing the areas in the following ways:

A- Quality Management;
B- Workforce Engagement in the Clinical Quality Management Program;
C- Measurement, Analysis, and Use of Data to Improve Program Performance;
D - Quality Improvement Initiatives;
E - Consumer Involvement;
F - CQM Program Evaluation;
G - Achievement of Outcomes;
H - HIV Continuum of Care;
I - Organizational Integration of HIV Supportive Service Programs and Clinical Activities

Each of these categories are provided grading criteria for the quality management committee to assign a numerical score of:

0 - Getting Started
1 - Planning & Initiation
2 - Beginning Implementation
3 - Implementation
4 - Progress towards systematic approach to quality
5 - Full systematic approach to quality management in place

Note on Use of NQC Part C/D OA Tool

Subrecipients will notice that the tool used for our Part B funded agencies is listed as an NQC Part C/D Organizational Assessment Tool. This is due to this version of the tool containing an evaluation section for consumer involvement that is not part of other assessment tool sections.

Quality Management committees should be using the prior year's completed assessment to guide the current years assessment efforts.

For each of the categories within the assessment, in order to assign a numerical value for the overall category, each checkbox provided for the scoring criteria needs to be checked.

We will use the following image of the first scoring section in the tool: A.1. Leadership.

A.1. To what extent does senior leadership create an environment that supports a focus on improving the quality of HIV care?		
Getting Started	0	☑ Senior leaders are not visibly engaged in the quality of care program.
Planning and initiation	1	Leaders are: ☑ Minimally involved in improvement efforts, quality meetings, or supporting provision of resources for QI activities. ☑ Primarily focused on external requirements and supporting compliance with regulations. ☑ Inconsistent in use of data to identify opportunities for improvement.
Beginning Implementation	2	Leaders are: ☑ Not engaged optimally. ☑ Engaged in quality of care with focus on use of data to identify opportunities for improvement. ☑ Somewhat involved in improvement efforts. ☑ Somewhat involved in quality meetings. ☑ Supporting some resources for QI activities.
Implementation	3	Leaders are: ☑ Providing routine leadership to support the clinical quality management program. ☑ Providing routine and consistent allocation of staff or staff time for QI. ☑ Actively engaged in QI planning and evaluation. ☑ Actively managing/leading quality meetings.

For quality committees that are already established and have an extensive history in implementing quality improvement efforts within their system of care, a majority of the boxes for Getting Started, Planning and Initiation and Beginning Implementation would already be checked.

These scoring criteria already checked off signals that these goals had been achieved during previous years quality management committees review and evaluation of the program. This is not to say that, for whatever reason, boxes couldn't become unchecked going from one year to the next.

Each previously checked/completed goal should still be evaluated by the quality committee to ensure that the goal remains a completed an operationalized component of the subrecipients quality management efforts.

Missing Checks

We can see in the example to the right that a checkmark was not achieved for the goal: "Promoting patient-centered care and consumer involvement through the CQM program"

		☑ Clearly communicating quality goals and objectives to all staff. ☑ Recognizing and supporting staff involved in QI. ☑ Routinely reviewing performance measures and patient outcomes to inform program priorities and data use for improvement. ☑ Attentive to national and/or local health care trends/priorities that pertain to the agencies.
Progress toward systematic approach to quality	4	Leaders are: ☑ Supporting development of a culture of QI across the program, including provision of resources for staff participation in QI learning opportunities such as seminars, professional conferences, QI story boards for distribution. ☑ Supporting prioritization of quality goals based on data, and critical areas of care are addressed in coordination with broader strategic goals for HIV care. ☐ Promoting patient-centered care and consumer involvement through the CQM program. ☑ Routinely engaged in QI planning and evaluation. ☑ Routinely providing input and feedback to QI teams.

This goal not being checked in the evaluation would signal to the quality committee that for this section, A.1. Leadership, the overall score would be assigned a 3. The numerical score will always correspond to the fully completed numerical category for that section.

QI Goals to obtain the Missing Check

The quality committee having identified a needed goal/objective of the program would then work to draft an improvement project for the coming year to be able to address the missing component. The overall aim being for the committee to work the next year implementing measures to obtain the check mark and be able to score this section a numerical 4.

This general theme of identifying all satisfied elements of a QM program, identifying opportunities for growth and improvement and then incorporating within the coming year's QM Plan means to achieve this growth should be applied to all categorical components within the Organizational Assessment Tool.

Technical Assistance is always available to subrecipients who have questions or need assistance in completing the Organizational Assessment Tool. HRSA HAB also offers extensive resources via their website located at https://ryanwhite.hrsa.gov/about/recipient-resources

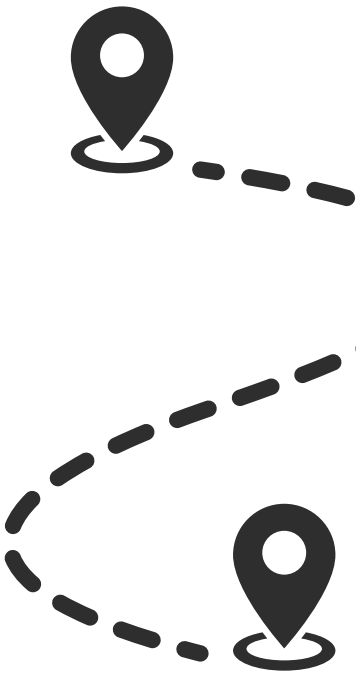
Section 8

Annual QI Projects

As part of the Clinical Quality Management (CQM) requirements: all Ryan White Part B Subrecipients are required to have an annual Quality Improvement project which is outlined in their agency's Quality Management Plan. This QM Plan and QI Project is submitted to the Lead Agency during the beginning of each grant year in the month of April and will be reviewed by the Lead Agency's Quality Manager and Program Manager or Director. Approval of the overall Quality Management Plan and Quality Improvement Project will be communicated to each agency's leadership utilizing a standardized evaluation tool developed by HRSA. The full tool is available in the Section 9 of this document.

Going into Grant Year (GY) 2025-2026, the Lead Agency asks that all Area 7 Ryan White agencies develop an annual Quality Improvement project which focuses on improving an aspect of health outcomes aimed at directly improving an aspect of the HIV care continuum not only for the agency, but also for Brevard County as a whole. Agencies could develop Improvement projects aimed at increasing viral load suppression in one of the priority populations mentioned previously in Section 4, or they could develop a project aimed at reducing the agency's percentage of Out of Care clients.

Below is a suggested timeline for your agency's QI project with dates outlined where the Lead Agency may request progress updates on your PDSA cycles and final outcomes:



Step 1	Submission of your agency's CQM Plan to Lead Agency	March 1, 2025
Step 2	Problem Identification and AIM Statement submission to Lead Agency	April 30, 2025
Step 3	PDSA Cycle Sheets Submitted Quarterly	April 30 2025 July 31 2025 October 31, 2025 January 31, 2026
Step 4	Evaluation of Data collection from all PDSA cycles in the year	February 28 2026
Step 5	Quality Improvement Poster	February 28 2026

Monthly QI Teams Calls

QI TA Calls will be hosted on the last Friday of every month and each agency is strongly encouraged to utilize this day to schedule time with the Lead Agency Quality Management Team to provide updates on your QI project and or to troubleshoot issues you might be encountering with your PDSA cycles.

Section 9

Area 7 QI Tools

There are numerous methods and QI tools which can be used to evaluate your agency's quality improvement efforts. While the use of specialized statistical analysis software is a viable option, often times getting subscriptions to or licensing for these platforms carries significant costs that are often times place their access out of reach for many programs.

Analysis of the data can be done more cost effectively by using already available platforms such as Excel and Powerpoint, which many agencies have easy access to through their employer's enterprise plans with Microsoft. Similar programs hosted by other entities such as Google are also viable means to analyze data.

It is important to note that during the evaluation phase of your Quality Improvement program, you should be evaluating more than just whether or not your anticipated improvement was realized by the end of the project. You should also be evaluating whether specific objectives in each PDSA cycle was achieved. Your team should likewise be evaluating how well the steps in each PDSA cycle were followed as well as assessing whether or not there were any unintended negative outcomes witnessed during any individual PDSA cycle or from the project overall.

Tools Commonly in Area 7 Quality Management

We are going to review a couple of the most commonly utilized tools for quality management which span the areas of Data Collection, Root Cause Analysis, and Presenting and Reporting Outcomes. This is by no means an exhaustive list of tools available to quality management committees and subrecipients are encouraged to expand their familiarity with these commonly used tools. Being able to leverage these and other resources helps to diversify and strengthen a subrecipient's quality management program.

This symbol will be utilized during this section of the toolkit to reference you to additional training resources on a given tool. There already exists extensive training & resources on how best to deploy and leverage these tools that can provide learners additional information beyond that which can be covered within this tool kit.

Below outlines the tools that we will be reviewing within this toolkit. The following pages we will provide brief descriptions of the tools and any considerations and best practices in deploying them.

Data Collection Tools

The majority of data collection occurs within CAREWare, the EMR approved for use by Part B subrecipients within Area 7. Outside of this platform other quantitative and qualitative data can be gathered by subrecipients in the form of consumer feedback surveys.

Root Cause Analysis Tools

We will be reviewing how to use the '5-why's' approach and the Fishbone (Ishikawa) Diagram.

Presenting & Reporting Outcomes

We will be reviewing the most common methods to display data which include line charts, bar charts, histograms; as well as reviewing the A3 Report which is submitted annually to the lead agency by all subrecipients.

Data Sources

The Area 7 Ryan White Part B Program utilizes CAREWare 6 (CW6) as the HIV information management system for reporting client level data and services. CW6 has a wide range of reporting capabilities that are available to providers which include Performance Measurement reports, Custom Reports. Attempting to outline all of the functionality within this toolkit would not be feasible, however there are readily available links to the User Guides for CW6 which can be found by visiting the link displayed next to the icon below

Additional information on the use CAREWare6 can be found by visiting: https://targethiv.org/library/careware-6-quick-start-guides-2019

Patient Reported Outcomes & Experiences

There are additional ways in which subrecipients are able to collect data based on client experiences and outcomes, the most common of which is by administering client satisfaction surveys. CQII has recently published the 'Patient-Reported Outcomes and Experiences' guide which aims to 'elevate patient voices to improve the quality of HIV treatment and care.' This is a fantasitc resource which all subrecipients are encouraged to leverage in their attempts to solicit consumer feedback on the care they receive.

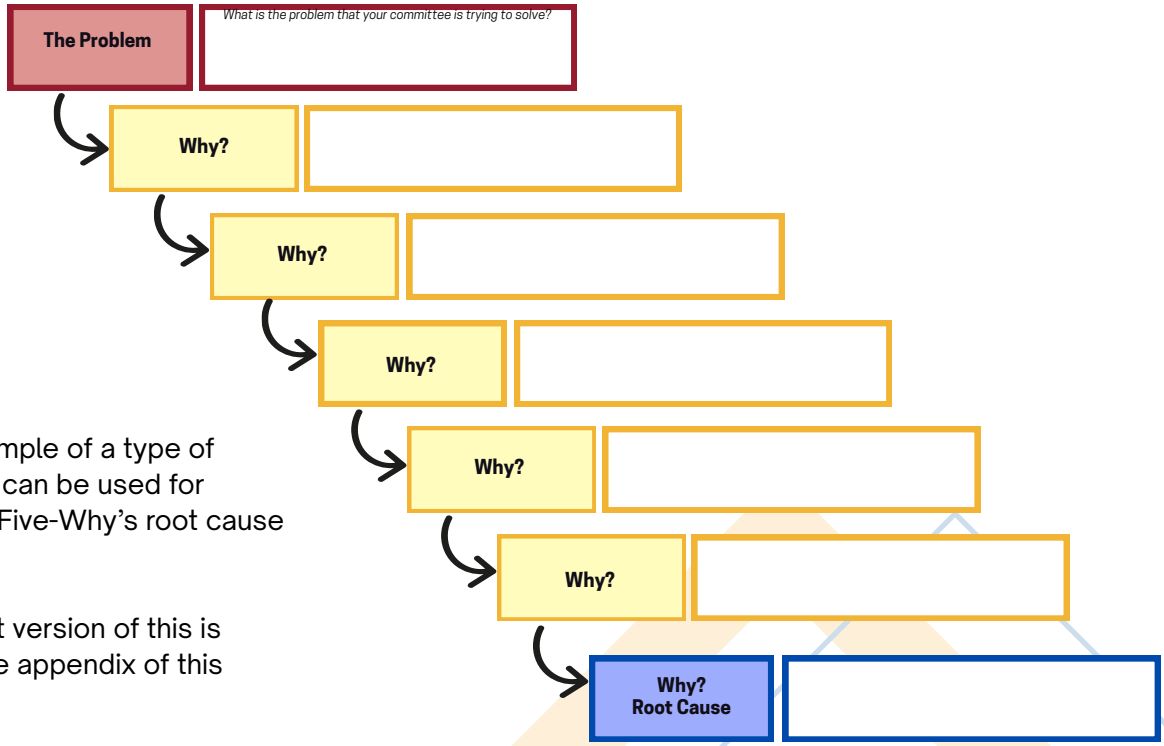
Additional information on the use CAREWare6 can be found by visiting: https://targethiv.org/cqii/proms-and-prems-outcome-and-experience-measures

Root Cause Analysis Methodologies

There are numerous methods available to QI Teams to conduct a Root Cause Analysis (RCA). The most prevalent methods identified within our area's subrecipient quality management plans are **The Five Why's**, **Fishbone Diagrams**, and **Pareto Charts**. While we will not be able to provide a comprehensive review of the use of the above named methods, it is our aim to provide a fundamental introduction to these methods and how they are used in a general sense. We will also link readers to additional instructional materials that can be found hosted on third-party platforms.

The Five Why's

The 5-Why's method is a Lean problem-solving tool that was designed to quickly identify the root cause of an identified issue by simply asking the question 'why' repeatedly. In the following sections we will review the necessary steps (Gather the Team, Define the Problem, The First Why, Keep Asking Why, Take Action, and Document your Findings).



This is an example of a type of template that can be used for completing a Five-Why's root cause analysis.

A large format version of this is included in the appendix of this toolkit

QI Tools continued

Steps to Five-Why's

Gather the Team

1

Completing a Five-Why's causal analysis is best completed with the entire quality management team. Having a diverse perspective from the different operational departments will enhance the committees ability to successfully identify potential root causes for an identified issue.

Define the Problem

2

The quality management committee should work together to accurately define the problem they are wishing to solve. The problem identified should be easily supported quantitatively based on either outcome or experience data that has been collected.

Example: Performance measure data for the most recent quarter illustrates that there has been a 12% decrease in the annual retention in care numbers overall for all Ryan White eligible clients at the agency.

The First Why

3

Once a problem has been identified, the first 'Why' will be asked of the committee for members to provide a potential answer to. In our example above, the question posed to the committee would be ***"Why has overall annual retention in care decreased 12% since last quarter?"*** QM Committee members would then offer up answers to this first why.

Keep asking Why

4

This process of asking 'Why' for each reason provided by the committee will continue until the root cause of the problem is identified. This is to ensure that the next step in the process, Take Action, is aimed at solving for the true driving variable contributing to the problem rather than a less significant driver

Take Action

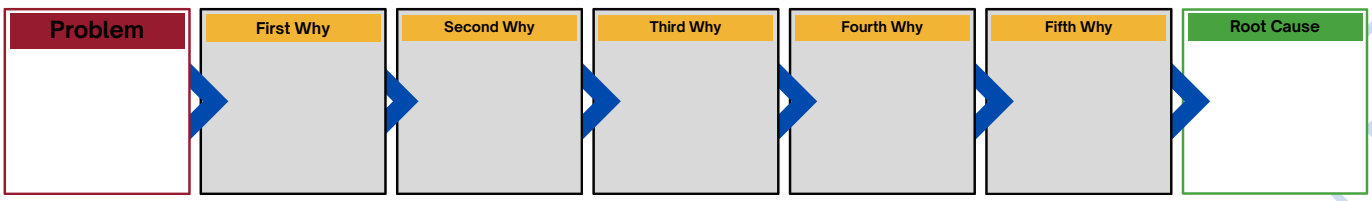
5

Once the Root Cause has been identified by the quality committee it's time to take action on creating an improvement process aimed at addressing the root cause. In theory and in practice, addressing the root cause of an issue within a system will begin to influence the observable outcomes. The type of action taken by the committee will always depend on the root cause being addressed. Sometimes the best course of action is to conduct focused in-service training with staff, other times it requires restructuring a process flow.

Document Your Findings

6

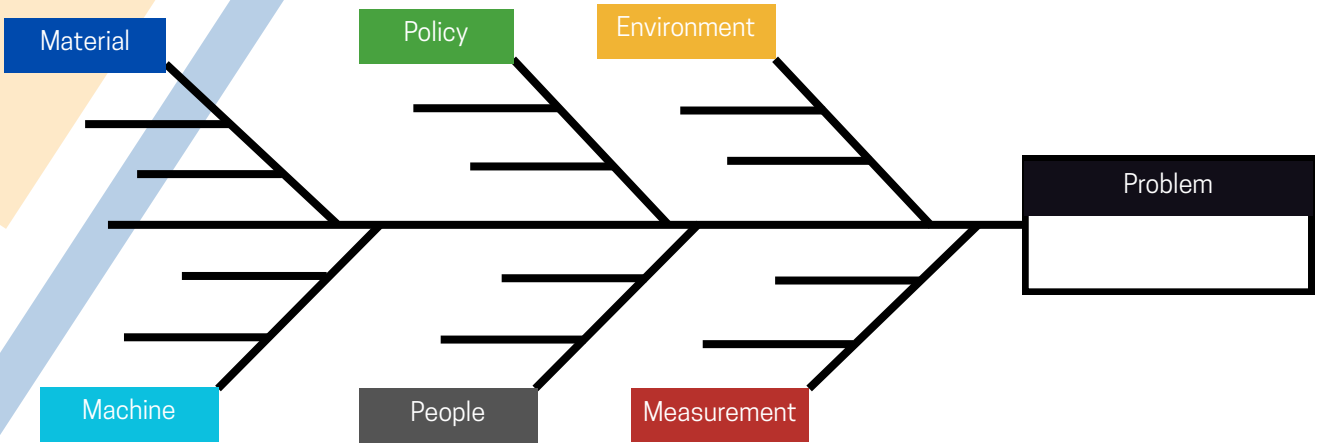
Documenting your 5-Why's process is an important step for quality management committees to complete. Most QM committees will prefer to use a specific template for the 5-Why's process. We have included a template in the Appendix of this toolkit for all Area 7 subrecipients to use.



Additional information on the Five Why's root cause analysis tool can be found by visiting: https://www.learnleansigma.com/root-cause-analysis/how-to-do-a-5-whys-analysis/

Fishbone Diagram

Also known as the Cause-and-Effect Diagram or Ishikawa, is a pictographic representation showing possible causes for a given effect. This method allows users to study all of the probable causes of why a process has potential failures and helps you to identify areas of data collection for further evaluation. In deployment of this RCA method, you will need to be able to clearly identify any major causes contributing to an effect and then identify any sub-causes within each main cause.



The Five-Why's technique is commonly used along with the Fishbone diagram to help identify the root cause of a problem.

Fishbone Diagram Structure

There are three main structures of the fishbone diagram, the 'head', the 'long bones', and the 'short bones'. We will briefly describe these three structures below.

The Head

The head of the fishbone diagram is where you label the problem your committee will be focusing on

Long Bone

The long bone is meant to represent potential main causes that are separated into main categories.

- Material
- Policy
- Environment
- Machine
- People
- Measurement

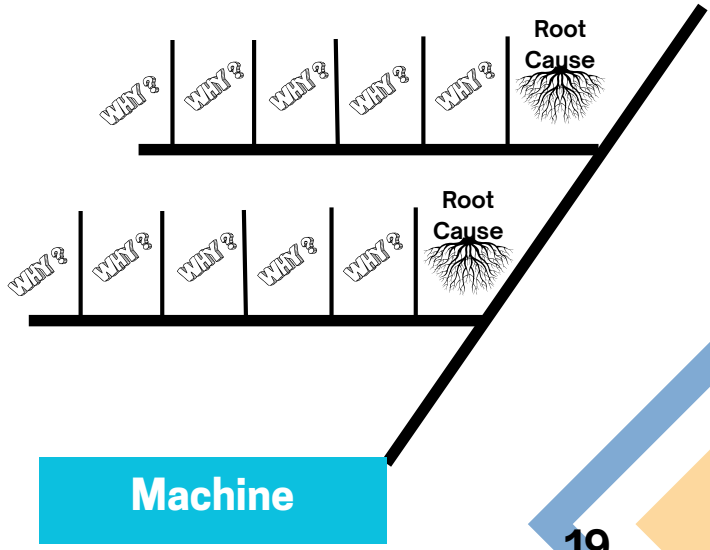
Short Bone

The short bones are meant to represent the possible causes identified as contributing to the main causes of the problem.

Five Whys & Fishbone (Ishikawa Why)

Many quality management committees like to combine the use of the fishbone diagram and the Five-Why's methodology when they are working to improve an identified problem. As your committee is identifying causes within any of the listed fishbone categories, you would want to apply the Five-Why's attempting to get to potential root causes within each category.

It's important for quality committees to remain aware that there exists the potential of identifying relevant as well as irrelevant root causes to the problem. This would lead to implementing improvement strategies that could potentially not address the problem.



Additional information on the use of Fishbone Diagrams can be found at:
https://www.schoolperformanceinstitute.org/blog/2020/3/5/improvement-science-tool-fishbone-diagram

Presenting & Reporting Outcomes

There are numerous ways in which outcome data can be presented for the purposes of tracking change improvement. The most common methods that are frequently utilized by providers and the Lead Agency are reporting **percentages**, displaying information in **bar-chart** format, and **line-chart** format. Annually Area 7 subrecipients are required to submit the outcomes of their annual quality improvement efforts via the **A3 Report**. We will briefly explore all of these different data reporting and visualization methods over the next few pages.

Ratios, Rates, and Percentages

Ratios, rates, and percentages help to standardize how data is displayed and relayed in a meaningful way. A ratio is a fraction which describes two groups relative to one another. An example of this would be describing the ratio of male clients to female clients within a clinic or agency. If we say that the ratio of male to female clients is 2:1, this means that for every 2 male clients there are 1 female client.

A rate is a ratio that describes a quantity in relation to a specific unit. An example of this would be expressing a clinic's no-show rate of 4 out of every 100 appointments.

Ratios and rates can also be displayed as percentages. In the above no-show example, the no-show rate would be 4%.

When we're presenting performance measure outcome data, we present this information as a percentage. For a given measure there are conditions set to identify clients that would comprise the numerator and denominator for each measure.

Anatomy of Measure Percentages

Numerator	**Clients from the denominator who meet the performance measurement criteria**
Denominator	**The denominator is comprised of all the clients for a given measure within a specific timeframe. This will change depending on the measure**

Let's examine our area's viral load suppression rate from the end of calendar year 2024.

Numerator

Our numerator will be comprised of all clients pooled for the denominator whose last viral load lab results indicated their viral load was less than 200 copies.

$$\frac{914}{1110}$$

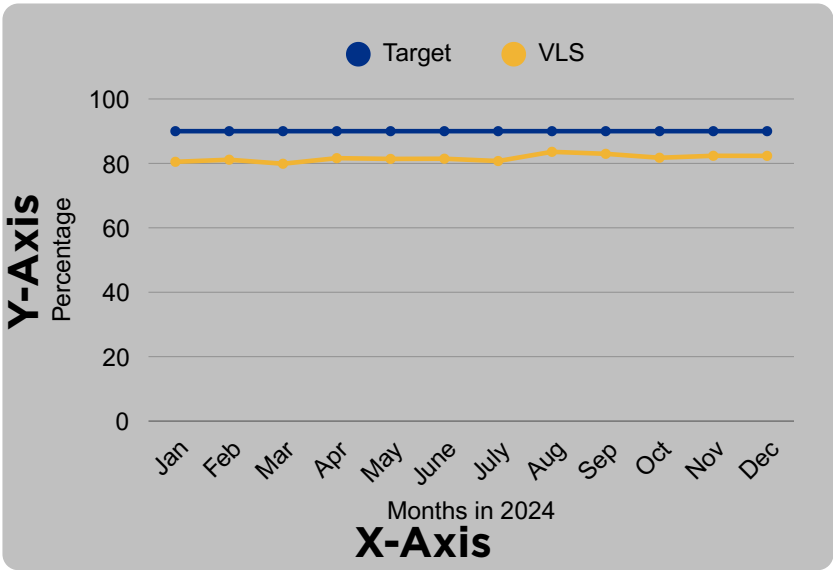
Denominator

When we're evaluating viral load suppression, we are wanting to pull in all clients who are HIV positive who had at least one medical visit in the past 12 months. This pool of clients will make up the denominator for our measure.

When we display this ratio of 914/1110 in a percentage, we get a value of 82.34%. It is generally best practice to only display to either the whole number or first decimal place. With this in mind, we reported that Area 7's overall Viral load suppression rate was **82%** at the end of the fourth quarter for calendar year 2024.

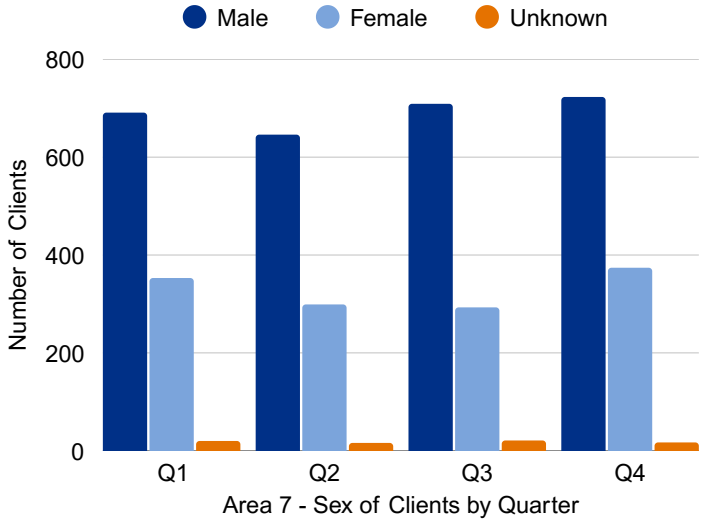
Line Graph / Run Charts

A line graph is a visual representation of how two variables are related to one another. It shows this information by drawing a continuous line between all of the points on the graph. Points on the graph are plotted on the field using the variables that are set for the horizontal axis (X-axis) and the vertical axis (Y-axis). The horizontal axis is usually identified as a measure of time and the vertical axis would be the quantitative value, usually quantity or percentage.



Run charts are a type of line graph which has a specific purpose of attempting to identify changing trends or deviations from central tendencies. Since central tendencies are the main focus of run charts, a median line will be used to be able to identify points which deviate away from centrality. An example of a run chart used in our area would be for the Eligibility Review Tool results spanning the 2024 - 2025 contract year.

Bar Charts

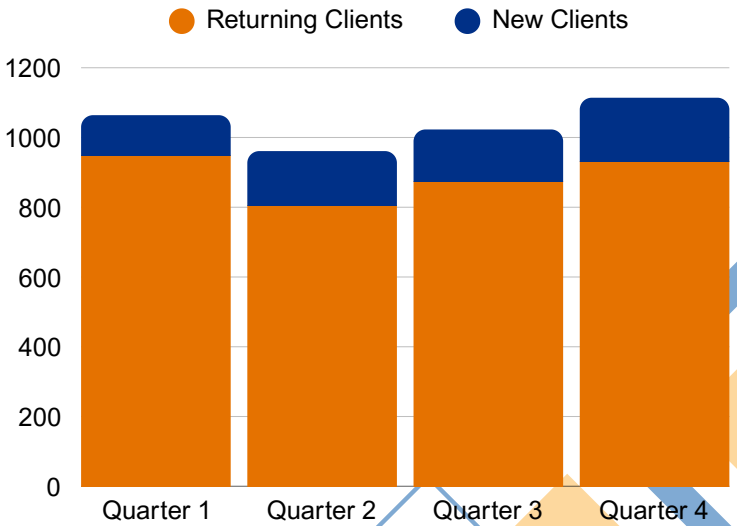


Bar Charts offer a way to display and present categorical data, where the categories are discrete values. We will often times elect to use a bar chart when we're reporting on area wide demographical data. This would include the composition of the different sexes, races and age ranges of the clients in our service area.

The Bar graph is comprised of vertical or horizontal bars which represent the categorical data that is being displayed. The height or length of the bar represents the quantity or frequency of occurance for a given category.

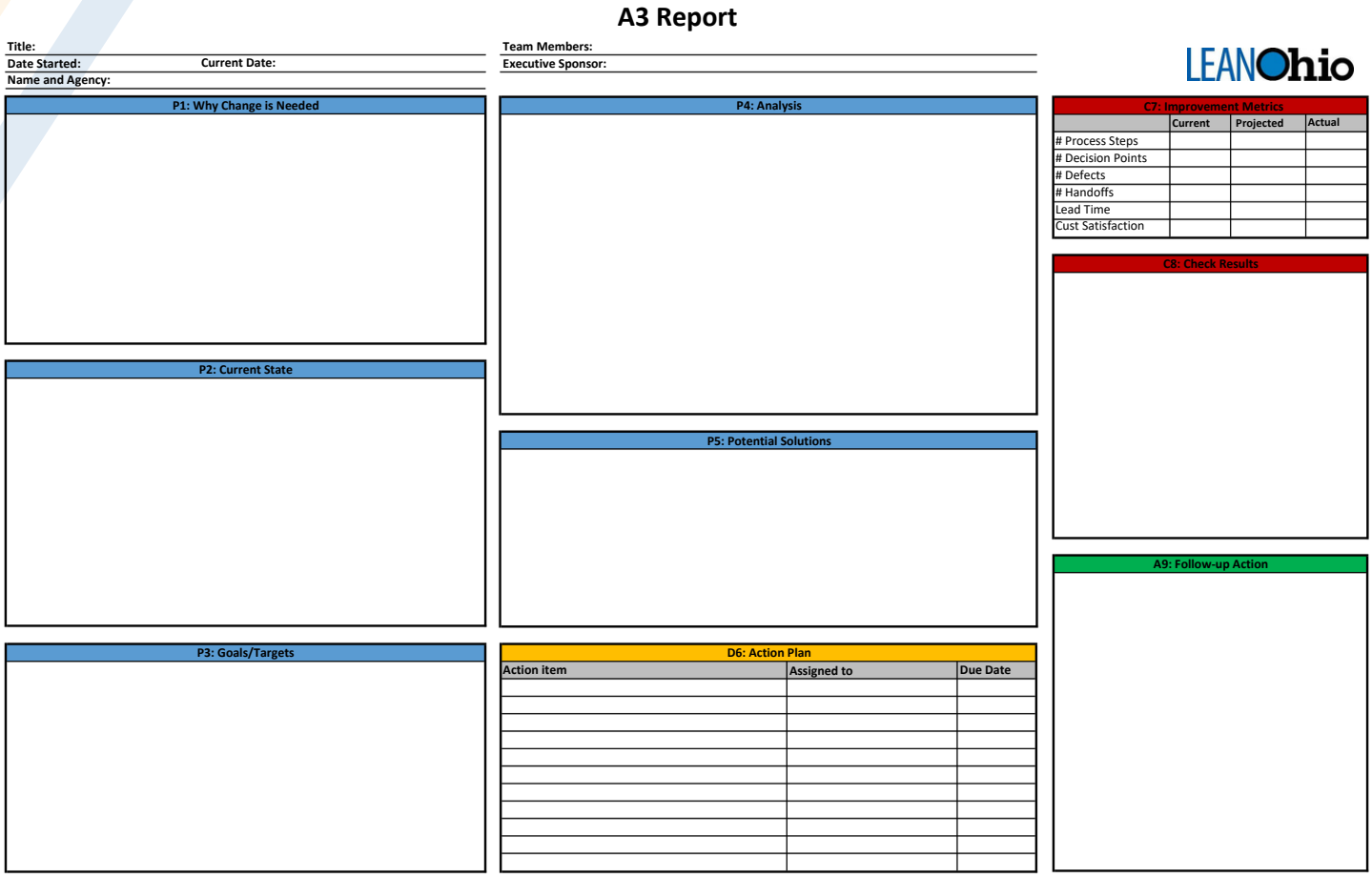
Bar graphs can display information in a multitude of ways as shown in the difference between the two charts on this page. The top chart shows clustered columns displaying the how the quantity or frequency of male, females, and unknown sex occurred within the service area across the four quarters of the year.

The bar graph to the right is a stacked column which shows the breakdown between new clients and returning clients within the total client count for each quarter of the year.



A3 Report - Problem Solving Tool

The A3 Report is included in all of Area 7's subrecipient's contracts as an annual deliverable for all providers to submit to the Lead Agency. The A3 report is the chosen reporting method for reporting on an agency's annual quality improvement project. This report is comprised of nine distinct sections which allows for quality committees to properly showcase their annual quality improvement efforts. We will use the space in this toolkit to briefly outline each of the areas of the A3 Report to help providers have a better understanding of what is expected from this tool.



P1. Why Change is Needed

This section is part of the Plan phase of the PDSA cycle and is where you will outline background data on why you're focusing on the problem and why it is important. This explains why your quality committee is committed to caring about this priority.

P2. Current State

The Current State section of the A3 is space for the quality committee to illustrate the extent of the current problem using baseline data and graphical representations of the state. Charts and flow-charts of the current state could be considered for inclusion in this section.

P3. Goals/Targets

This planning section outlines what the future state of the system should look like. This is accomplished by outlining what success will look like if your project is successful. QM Committees can outline what gaps exist that need to be addressed as well as needed specific improvements in performance to reach the goal or target.

P4. Analysis

This planning section of the A3 tool is dedicated space for the committee's analysis of the problem. Findings from any root cause analysis conducted should be listed in this section. QM Committees could choose to include any digital representation of fishbone diagrams or five-why's processes.

P5. Potential Solutions

In this section, quality committees should outline how they synthesized all of the data obtained in the previous four planning sections. Potential solutions would be identified and culminate in a solution hypothesis.

D6. Action Plan

This is the 'Do' part of the improvement process. Any action plan created to test your improvement theory should be outlined within this section of the A3 Report. Key steps or actions and their responsible parties should be identified.

C7. Improvement Metrics

This is the 'Study' section of the A3 report where data from the test is evaluated. QM Committees should evaluate what went well and what went wrong during the testing phase. Any refinement in the process should also be identified in this section.

C8. Check Results

This section is intendended to allow for quality committees to be able to identify any results of the test that were observed, but were difficult to quantify. Any reported impacts on qualitative data should be identified in this section.

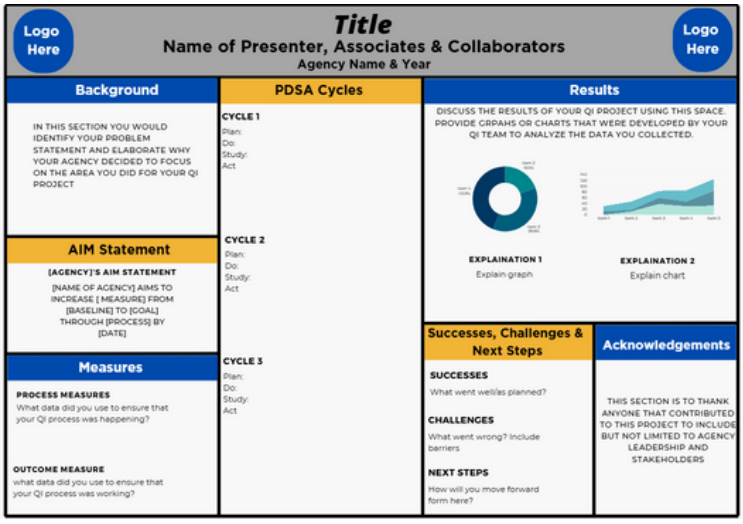
A9. Follow-up Action

This 'Act' section of the A3 Report outlines the follow up actions that were taken by the quality committee based on the change improvement tests carried out. Successful tests should be implemented on a larger scale, if not system wide. Unsuccessful test should be modified in it's approach or even abandoned in lieu of a different change hypothesis. This section outlines what the road ahead looks like after completion of this quality improvement project.

Additional information on the use of the Lean Ohio A3 Report can be found by visiting https://dam.assets.ohio.gov/image/upload/das.ohio.gov/employee-relations/LeanOhio/Resources/A3_PDCA_Final_2_22_2018.pdf

Novel QI Poster Reporting Template

Similar to the A3 Report, we have created a reporting template using Canva for Area 7 subrecipients to consider using to showcase their Quality Improvement projects from year to year. A full copy of this template has been included in the Appendix of this Toolkit. An editable PowerPoint version of the report template will be made available on the Area 7 Resource Hub. While it is not a directive or requirement for the poster template to be used, the additional tool and resource has been made available for our providers.



Living Document Status

This toolkit is intended to become a living document within each of your agencies. The hopes being that after Heart of Florida United Way is no longer managing the Ryan White Program for this Area, the subrecipients would be able to take this toolkit and continually add to the tools and methodologies respective to each organization's unique quality management needs and infrastructure.

Additional Resources

Below is a list of resources that were referenced and used when compiling the contents of this toolkit.

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Hessing, T. (2014, January 20). *Run Chart: Creation, Analysis, & Rules*. Six Sigma Study Guide. https://sixsigmastudyguide.com/run-chart/

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Journal of Patient-Reported Outcomes. (2024). *Preparing to download ...* Nih.gov. https://pmc.ncbi.nlm.nih.gov/articles/PMC11568099/pdf/41687_2024_Article_795.pdf

Kumah A, Nwogu CN, Issah AR, Obot E, Kanamitie DT, Sifa JS, Aidoo LA. Cause-and-Effect (Fishbone) Diagram: A Tool for Generating and Organizing Quality Improvement Ideas. Glob J Qual Saf Healthc. 2024 May 2;7(2):85-87. doi: 10.36401/JQSH-23-42. PMID: 38725884; PMCID: PMC11077513.

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Memiah, P., Tlale, J., Shimabale, M., Nzyoka, S., Komba, P., Sebeza, J., Tina, A., & Makokha, V. (2021). Continuous quality improvement (CQI) Institutionalization to reach 95:95:95 HIV targets: a multicountry experience from the Global South. *BMC Health Services Research*, *21*(1). https://doi.org/10.1186/s12913-021-06731-7

National Quality Center, New York State Department of Health AIDS Institute, & Health Resources and Services Administration HIV/AIDS Bureau. (2009). *NQC Training of Quality Leaders Guide* (1st ed., Vol. 1). National Quality Center. https://targethiv.org/sites/default/files/supporting-files/TQL%20Facilitators%20Guide.pdf

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Target HIV. (2019, June 27). *CAREWare 6 Quick Start Guides | TargetHIV*. Targethiv.org; TargetHIV. https://targethiv.org/library/careware-6-quick-start-guides-2019

Appendix

Below lists all of the various tools that have been referenced throughout the text of this toolkit. There are a mix of tools that have been made by HFUW and others that are readily available on the internet. Some of the tools have had thematic changes to the documents to match the theme of this toolkit but no changes to substance or content were made to the tools.

- A — Appendix A: RWHAP Organizational Assessment Tool
- B — Appendix B: RWHAP CQM Check List
- C — Appendix C: HFUW RWB PDSA Template
- D — Appendix D: HFUW Five Whys Template
- E — Appendix E: A3 Report
- F — Appendix F: QI Poster Template

NATIONAL QUALITY CENTER

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

Updated June 2017

NEW YORK state department of HEALTH

AIDS Institute

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

Purpose of the Organizational Assessment:

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

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

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

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

A. Quality Management

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

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

Leadership

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

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

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

Quality Management Plan

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

Clinical Quality Management Committee

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

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

Getting Started	0	☐ Senior leaders are not visibly engaged in the quality of care program.
Planning and initiation	1	Leaders are: ☐ Minimally involved in improvement efforts, quality meetings, or supporting provision of resources for QI activities. ☐ Primarily focused on external requirements and supporting compliance with regulations. ☐ Inconsistent in use of data to identify opportunities for improvement.
Beginning Implementation	2	Leaders are: ☐ Not engaged optimally. ☐ Engaged in quality of care with focus on use of data to identify opportunities for improvement. ☐ Somewhat involved in improvement efforts. ☐ Somewhat involved in quality meetings. ☐ Supporting some resources for QI activities.
Implementation	3	Leaders are: ☐ Providing routine leadership to support the clinical quality management program. ☐ Providing routine and consistent allocation of staff or staff time for QI. ☐ Actively engaged in QI planning and evaluation. ☐ Actively managing/leading quality meetings.

		▯ Clearly communicating quality goals and objectives to all staff. ▯ Recognizing and supporting staff involved in QI. ▯ Routinely reviewing performance measures and patient outcomes to inform program priorities and data use for improvement. ▯ Attentive to national and/or local health care trends/priorities that pertain to the agencies.
Progress toward systematic approach to quality	4	Leaders are: ▯ Supporting development of a culture of QI across the program, including provision of resources for staff participation in QI learning opportunities such as seminars, professional conferences, QI story boards for distribution. ▯ Supporting prioritization of quality goals based on data, and critical areas of care are addressed in coordination with broader strategic goals for HIV care. ▯ Promoting patient-centered care and consumer involvement through the CQM program. ▯ Routinely engaged in QI planning and evaluation. ▯ Routinely providing input and feedback to QI teams.
Full systematic approach to quality management in place	5	Leaders are: ▯ Actively engaged in the implementation and shaping of a culture of QI across the program, including provision of resources for staff participation in QI learning opportunities such as seminars, professional conferences, QI story boards for distribution. ▯ Encouraging open communication through routine team meetings and dedicated time for staff feedback. ▯ Routinely, actively, and consistently engaged in QI planning and evaluation. ▯ Routinely, actively, and consistently providing input and feedback to QI teams. ▯ Encouraging staff innovation through QI awards or incentives. ▯ Directly linking QI activities back to institutional strategic plans and initiatives.
A.2. To what extent does the HIV program have an effective clinical quality management committee to oversee, guide, assess, and improve the quality of HIV services?		
Getting Started	0	▯ A clinical quality management committee has not yet been developed or formalized, or is not currently meeting regularly to provide effective oversight for the CQM program.
Planning and initiation	1	The quality committee: ▯ May review data triggered by an event or problem, or generated by donor or regulatory urging. ▯ Is minimally integrating quality activities into other existing meetings.
Beginning Implementation	2	The quality committee: ▯ Has plans to hold regular meetings, but meetings may not occur regularly and/or do not focus on performance data. ▯ Has been formalized, representing most institutional disciplines. ▯ Has identified roles and responsibilities for participating individuals.
Implementation	3	The quality committee: ▯ Is formally established and led by a program director, quality coordinator, medical director, or senior clinician. ▯ Has implemented a structured process to review data for improvement. ▯ Has drafted a workplan/calendar but it is not actively used to guide timely progress. ▯ Has defined roles and responsibilities as codified in the quality management plan. ▯ Reviews performance data regularly, including staff and consumer satisfaction, if available. ▯ Discusses QI progress and redirects teams as appropriate.
Progress toward systematic approach to quality	4	The quality committee: ▯ Represents all key Ryan White HIV/AIDS Program funded disciplines. ▯ Has established a performance review process to regularly evaluate clinical measures and respond to results as appropriate, including staff and consumer satisfaction. ▯ Communicates with non-members through distribution/accessible posting of minutes, and discussion in regular staff meetings. ▯ Actively utilizes an annual workplan/calendar to closely monitor progress of quality activities and team projects. ▯ Provides progress reports to the organization-wide quality program, if appropriate.

Full systematic approach to quality management in place	5	The quality committee: Is a formal entity led by a senior clinician or administrator and, where appropriate, is linked to organizational quality committees through common members. Is responsive to changes in treatment guidelines and external/national priorities (HAB, CMS), which are considered in development of indicators and choosing improvement initiatives. Has fully engaged senior leadership and they lead discussions during committee meetings. Effectively communicates activities, annual goals performance results, and progress on improvement initiatives to all stakeholders, including staff, consumers, and board members.
A.3. To what degree does the HIV program have a written comprehensive quality plan that is actively utilized to oversee quality improvement activities?		
Getting Started	0	A quality plan, including elements necessary to guide the administration of a CQM program, has not been developed.
Planning and initiation	1	The quality plan: Is written with some of the essential components necessary to direct an effective CQM program (see level 3). May be written for the parent organization or for the network, but plans specific to the HIV program or for the network have not yet been developed.
Beginning Implementation	2	The quality plan: Is written for the HIV program, and contains some of the essential components (see level 3). Is under review for approval (if required by organization) by senior leadership, and includes steps for implementation.
Implementation	3	The quality plan: Reflects in an effective HIV-specific clinical quality management program with all of the essential QI components including: • Quality statement • Quality infrastructure definition and roles • Performance measures • Annual quality goals based on the prior year's results • Participation of stakeholders • Evaluation • Capacity building • Process to update the QM plan • Communication methodology to share information • CQM plan implementation timeline Is routinely communicated to program staff. Includes an annual workplan/timeline outlining key activities of the CQM program, improvement initiatives, and accountable individuals/teams.
Progress toward systematic approach to quality	4	The quality plan: Has been implemented and regularly used by the quality committee to direct the CQM program. Includes annual goals identified on the basis of internal performance measures and external requirements through engagement of the quality committee and staff. Includes a workplan, which is modified as needed and at least once/year to achieve annual goals. Is routinely communicated to stakeholders including staff, consumers, board members, and the parent organizations, as appropriate. Is evaluated annually by the CQM committee to ensure that the needs of all stakeholders are addressed and that changes in the healthcare and regulatory environment are assessed to ensure that the program meets the changing needs of the HIV patient.
Full systematic approach to quality management in place	5	The quality plan: Is written, implemented, and regularly utilized by the quality committee to direct the CQM program, and includes all necessary components (see level 3).

		☐ Includes regularly updated annual goals that were identified by the quality committee using data on internal performance measures and external requirements through engagement of the quality committee and staff. ☐ Includes a comprehensive workplan/timeline outlining key activities in place and is routinely and consistently used to track progress on performance measures and improvement initiatives, and modified as needed to achieve annual goals. ☐ Is aligned with that of the parent organization and/or all network sites, as appropriate.
Comments:		

B. Workforce Engagement in the HIV Clinical Quality Management Program

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

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

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

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

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

Getting Started	0	☐ No staff (clinical and non-clinical) are routinely engaged in QI activities nor provided training to enhanceskills, knowledge, theory, or methodology, nor are they encouraged to identify opportunities for improvement or to develop effective solutions.
Planning and initiation	1	Engagement of core staff in QI (clinical and non-clinical): ☐ Is under development and include some training in QI methods and provides opportunities to attend meetings where QI projects are discussed.
Beginning Implementation	2	Engagement of core staff in QI (clinical and non-clinical): ☐ Is underway and some staff have been trained in QI methodology. ☐ Includes QI meetings attended by some designated staff.
Implementation	3	Engagement of core staff in QI (clinical and non-clinical) includes: ☐ Attendance in at least one training in QI methodology. ☐ Staff members are generally aware of program QI activities (quality plan/priorities). ☐ Involvement in QI projects, project selection, and participation in a CQM committee. ☐ Discussion and review of QI projects during staff meetings. ☐ Defined staff roles and responsibilities related to QI. ☐ Physicians and staff are aware of the quality plan and priorities for improvement.

Progress toward systematic approach to quality	4	Engagement of core staff in QI (clinical and non-clinical) includes: □ Demonstrated evidence that staff members are engaged and encouraged to use QI skills to identify opportunities for improvements and to develop solutions. □ A shared language regarding quality, which is evidenced in routine discussion. □ Description in the annual quality plan, describing staff training, roles and responsibilities regarding staff involvement in QI activities. □ A description of quality activities included in staff job descriptions, and staff engagement in quality activities is used in staff evaluation. □ A formal process for recognizing staff performance internally and QI teams are provided opportunities to present successful projects to all staff and leadership.
Full systematic approach to quality management in place	5	Engagement of core staff in QI (clinical and non-clinical) includes: □ Staff awareness of the importance of quality and continuous improvement, and their participation in identifying QI issues, developing strategies for improvement, and implementing strategies. □ Regular and continuous QI education, and training in QI methodology. □ Leadership who encourages all staff to make needed changes and improve systems for sustainable improvement, including the necessary data to support decisions. □ Formal and informal discussions where teamwork is openly encouraged and leadership shapes teamwork behavior. □ Routine communication about new developments in QI, including promotion of QI projects both internally (e.g., staff meetings) and externally (e.g., related conferences). □ Opportunities for abstract development and submission to relevant professional conferences and authorship of related publications about development and implementation of institutional CQM programs.
Comments:		

C. Measurement, Analysis, and Use of Data to Improve Program Performance

GOAL: To assess how the HIV program uses data and information to identify opportunities for improvement, develops measures to evaluate the success of change initiatives, to align initiatives, and to monitor program status; and to ensure that accurate, timely data and information are available to stakeholders throughout the organization to drive effective decisions.

This section assesses how the program selects, gathers, analyzes, and uses data to improve performance. This includes how leaders conduct performance reviews to ensure that actions are taken, when appropriate, to achieve program goals.

C.1. To what extent does the HIV program routinely measure performance and use data for improvement?

Getting Started	0	□ Performance measures have not been identified.
Planning and initiation	1	Performance measures: □ Have been identified to evaluate some components of the program, but do not cover all significant aspects of service delivery. □ Are defined and used by personnel at some but not all units or sites. Performance data: □ Collection is planned pending initiation.
Beginning Implementation	2	Performance measures: □ Are externally defined and used by personnel at all applicable sites. Performance data: □ Validation, analysis, and interpretation of results on measures are in early stages of development and use. □ Results are occasionally shared with staff and patients.

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

D. Quality Improvement Initiatives

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

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

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

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

Getting Started	0	☐ Formal quality improvement projects have not yet been initiated in the CQM program.
Planning and initiation	1	QI initiatives: ☐ No, or limited assessment of organizational performance or system level analysis of data performed, are not team-based, and do not use specific tools or methodology. ☐ Reviews are primarily used for inspection.
Beginning Implementation	2	QI initiatives: ☐ Are prioritized by the CQM committee based on program goals, objectives, and analysis of performance measurement data. ☐ Involve team leaders and team members who are assigned by the CQM committee or other leadership. ☐ Begin to use specific tools or methodology to understand causes and make effective changes.
Implementation	3	QI initiatives: ☐ Are ongoing based on analysis of performance data and other program information, including external reviews and assessments. ☐ Focus on processes of care, in which QI methodology is routinely utilized. ☐ Are regularly documented and provided to CQM committee. ☐ Involve staff on QI teams. Cross departmental/cross functional teams are developed depending on specific project needs.
Progress toward systematic approach to quality	4	QI initiatives: ☐ Reflect input from staff through a transparent process. ☐ Routinely and consistently reinforce and promote a culture of quality improvement throughout the program through shared accountability and responsibility of identified improvement priorities. ☐ Are supported with appropriate resources to achieve effective and sustainable results. ☐ Involve support of data collection with results routinely reported to QI project teams.
Full systematic approach to quality management in place	5	QI initiatives: ☐ Are ongoing in every key service category. ☐ Are guided by a team leader or sponsor, and include all relevant staff depending on specific project needs. ☐ Correspond with a structured process for prioritization based on analysis of performance data and other factors. ☐ Are implemented by project teams. Further, clinicians and staff can identify an improvement opportunity at any point in time and suggest a QI team be initiated. ☐ Consistently and routinely utilize robust process improvement and multidisciplinary teams to identify actual causes of variation and apply effective sustainable solutions. ☐ Are regularly communicated to the CQM committee, staff, and patients. ☐ Routinely involve consumers on QI project teams. ☐ Are presented in storyboard context or other formats and reported to larger organization and/or placed in public areas for staff and patients (if relevant).

		☐ Involve recognition of successful teamwork by senior leadership. ☐ Are supported by development of sustainability plans.
Comments:		

E. Consumer Involvement

GOAL: This section assesses the extent to which consumer involvement is formally integrated into the clinical quality management program.

Consumer involvement encompasses the diversity of individuals using HIV programmatic services and can be achieved in multiple ways including solicitation of consumer perspectives through focus groups, key informant interviews, and satisfaction surveys; a formal consumer advisory board that is actively engaged in improvement work; consumers as members of program committees and boards; and conducting consumer needs assessments and including consumers in specific QI initiatives. Ideally, consumers have a venue to identify improvement concerns and are integrated into the process to find solutions and develop improvement strategies. Overall, consumers are considered valued members of the CQM program, where consumer perspectives are solicited, information is used for performance improvement, and feedback is provided to consumers.

E.1. To what extent are consumers effectively engaged and involved in the HIV clinical quality management program?

Getting Started	0	☐ There is currently no process to involve consumers in HIV CQM quality management program activities.
Planning and Initiation	1	Consumer involvement: ☐ No formal process is in place for ongoing and systematic participation in CQM quality management program activities. ☐ Is occasionally addressed by soliciting consumer feedback.
Beginning Implementation	2	Consumer involvement: ☐ Is addressed by soliciting consumer feedback, with plans for the development of a formal process for ongoing and systematic participation in clinical quality management program activities.
Implementation	3	Consumer involvement: ☐ Includes engagement with consumers to solicit perspectives and experiences related to quality of care. ☐ Is formally part of HIV CQM program activities through a formal consumer advisory committee, satisfaction surveys, interviews, focus groups, or consumer training/skills building. However, the extent to which consumers participate in program activities is not documented or assessed.
Progress toward systematic approach to quality	4	Consumer involvement: ☐ Is part of a formal process for consumers to participate in HIV CQR program activities, including a formal consumer advisory committee, surveys, interviews, focus groups, and/or consumer training/skills building. ☐ In improvement activities includes three or more of the following: – sharing performance data, QI activities and discussing quality during consumer advisory board meetings. – documenting in the HIV quality management plan. – membership on the internal quality management team or committee. – training on quality management principles and methodologies. – engagement to make recommendations based on performance data results. – increasing documentation of recommendations by consumers to implement QI projects. ☐ Information gathered through the above noted activities is documented and used to improve the quality of care.
Full systematic approach to quality	5	Consumer involvement: ☐ Contribution and its impact on quality is reviewed with consumers.

management in place		☐ Is part of a formal, well-documented process for consumers to participate in HIV CQM program activities, including a consumer advisory committee with regular meetings, consumer surveys, interviews, focus groups, and consumer training/skills building. ☐ In quality improvement activities includes four or more of the items bulleted in E1#4. ☐ Information gathered through the above noted activities is documented, assessed, and used to drive QI projects and establish priorities for improvement. ☐ Includes work with program staff to review changes made based on recommendations received with opportunities to offer refinements for improvements. Information is gathered in this process and used to improve the quality of care. ☐ Involves at minimum, an annual review by the clinical quality management committee of successes and challenges of consumer involvement in CQM program activities to foster and enhance collaboration between consumers and providers engaged in quality improvement.
Comments:		

F. CQM Program Evaluation

GOAL: To assess how the program evaluates the extent to which it is meeting the identified program goals related to quality improvement planning, priorities, and implementation.

Quality program evaluation can occur at any point during the cycle of quality activities, but should occur annually at a minimum. The process of evaluation should be linked closely to the quality plan goals: to assess what worked and what did not, to determine ongoing improvement needs and to facilitate planning for the upcoming year. The evaluation examines the methodology, infrastructure and processes, and assesses whether or not these led to expected improvements and desired outcomes. At a minimum, the evaluation should assess access to data to drive improvements, success of QI project teams, and effectiveness of quality structure. Where appropriate, external evaluations and assessments should be utilized in partnership with the internal evaluation. The evaluation is most effectively performed by program leadership and the program's clinical quality management committee, optimally with some degree of consumer involvement.

F.1. Is a process in place to evaluate the HIV program's infrastructure and activities, and processes and systems to ensure attainment of quality goals, objective, and outcomes?

Getting Started	0	☐ No formal process is established to evaluate the CQR program.
Planning and Initiation	1	Quality program evaluation: ☐ To assess program processes and systems is exclusively external.
Beginning Implementation	2	Quality program evaluation: ☐ Is part of a formal process and is integrated into annual QM plan development.
Implementation	3	Quality program evaluation: ☐ Occurs annually, conducted by the quality committee, and includes QM plan and workplan updates and revisions. ☐ Involves annual (at minimum) revision of quality goals and objectives to reflect current improvement needs. ☐ Results are used to plan for future quality efforts. ☐ Includes a summary of improvements and performance measurement trends to document and assess the success of QI projects. ☐ Results, noted above, are shared with consumers and other key stakeholders.
Progress toward systematic approach to quality	4	Quality program evaluation: ☐ Findings are integrated into the annual QM plan and used to develop and revise program priorities. ☐ Is reviewed during clinical quality management committee meetings to assess progress toward planning goals and objectives. ☐ Includes review of performance data, which is used to inform decisions about potential changes to measures.

		▯ Is used to determine new performance measures based on new priorities. ▯ Includes analysis of QI interventions to inform changes in program policies and procedures to support sustainability.
Full systematic approach to quality management in place	5	Quality program evaluation: ▯ Findings are integrated into routine program activities as part of a systematic process for assessing quality activities, outcomes and progress toward goals. Data and information are provided regularly to the CQM committee. ▯ Is used by the CQM committee to regularly assess the success of QI project work, successful interventions, and other markers of improved care. ▯ Includes data reflecting improvement initiatives, and is presented to ensure comprehensive analysis of all quality activities. ▯ Uses a detailed assessment process. The results of this assessment are utilized to revise and update the annual QM plan, adjust the HIV program priorities, and identify gaps in the program. ▯ Includes an analysis of progress towards goals and objectives and CQM program successes and accomplishments. ▯ Describes performance measurement trends, which are used to inform future improvement efforts. ▯ Communicates evidence that QI efforts informed through this process resulted in measurable change.
Comments:		

G. Achievement of Outcomes

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

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

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

Getting Started	0	▯ No clinical performance results are routinely reviewed or used to guide improvement activities.
Planning & Initiation	1	Data: ▯ Some measures are routinely reviewed and used to guide improvement activities. ▯ Trends for at least one measures is reported to determine if improvement occurs over time.
Beginning Implementation	2	Data: ▯ Results for most measures are routinely reviewed and used to guide improvement activities. ▯ Trends for some measures are reported.
Implementation	3	Data: ▯ Results for all measures are routinely reviewed and used to guide improvement activities, including viral suppression and retention in care. ▯ Trends for most measures are reported and some show improving trends over time. ▯ Results are compared to a larger aggregate data set for at least 2 outcome measures: viral suppression and retention in care. ▯ Comparison to larger aggregate data set is used to set programmatic targets.

Progress toward systematic approach to quality	4	Data: □ Comparison to larger aggregate data set is used to set programmatic targets, and targets are met for at least 50% of measures. □ Results for viral suppression and retention in care scores are equal to or greater than the 75th percentile of comparative data set.
Full systematic approach to quality management in place	5	Data: □ Trends are reported for all measures and most show sustained improvement over time in areas of importance aligned with organizational goals. □ Comparison to larger aggregate data set is used to set programmatic targets, and targets are met for at least 75% of measures. □ Results for viral suppression and retention in care scores are above the 75th percentile of comparative data set.
G.2. To what extent does the HIV program measure disparities in care and patient outcomes, and use performance data to improve care to eliminate or mitigate discernible disparities?		
Getting Started	0	□ No clinical performance results are routinely reviewed or used to address disparities.
Planning & Initiation	1	Performance measures/data: □ Are stratified for analysis of disparities by gender, age, SES, risk factor, geography, etc.
Beginning Implementation	2	Performance measures/data: □ Are used to identify disparities. □ Are used to plan improvement strategies to reduce disparities in HIV care.
Implementation	3	Performance measures/data: □ Are used to develop and implement general improvement strategies.
Progress toward systematic approach to quality	4	Performance measures/data: □ Are used to develop and implement general and targeted improvement strategies based on data analysis. □ Demonstrate some evidence of improvement of outcomes for identified disparities.
Full systematic approach to quality management in place	5	Performance measures/data: □ Demonstrate sustained evidence of improvement of outcomes for identified disparities.
Comments:		

H. HIV Care Continuum

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

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

H.1. To what extent does the HIV program routinely generate and use facility level care continuum to drive improvement and address gaps in care?		
Getting Started	0	□ Facility does not report required rates of retention, treatment and viral suppression.
Planning & Initiation	1	Facility: □ Reports required rates of treatment, retention, and viral suppression.

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

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

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

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

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

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

Getting Started	0	Organization: ▯ Program has no history of involving supportive service programs in CQM efforts.

Planning & Initiation	1	Organization: • Supportive services conduct QI activities and have their own closed CQM committee but these are separate from the HIV clinical CQM program. • HIV QM plan does not reference supportive service activities. • HIV CQM committee meetings occur without representation from supportive services.
Beginning Implementation	2	Organization: • Supportive service QI efforts are often separate, but they are reported to QM program at the HIV program's CQM committee as evidenced in meeting minutes. • Has a communication structure in place to inform clinic and supportive services of QI activities. This may include dissemination of meeting minutes to all staff in supportive and clinical programs, newsletters, email blasts or meeting discussions documented in meeting minutes. • Supportive services participate in clinical HIV CQM committee but in a limited manner (e.g., supportive service supervisors report on projects in supportive services, comment on clinical QI projects). However, they do not participate in integrated QI projects with both supportive services and clinical services working on the same QI team with the same QI goals.
Implementation	3	Organization: • Includes some supportive services in HIV CQM program. For instance, case management and care coordination services might be included in CQM committee meetings while food services might not. • Data collection plans for supportive service programs are included as a component of the HIV CQM program's annual QM plan. • CQM committee has reviewed QI activities conducted by supportive services and has a written plan to better integrate them with clinical efforts.
Progress toward systematic approach to quality	4	Organization: • The quality statement and goals included in the program's annual quality plan include all HIV services. • Data collected in supportive service programs are reviewed and used in clinical QI efforts. • Demonstrates through integrated quality meetings, and improvement projects as well as in the goals and activities delineated in the annual quality plan that the QM mission of clinical and supportive services are well-aligned.
Full systematic approach to quality management in place	5	Organization: • Has a fully integrated organizational QM plan that includes annual workplans for each supportive service program, as well as integrated goals that include plans to work towards goals with collaborative QI activities including both clinical and supportive services on QI teams. • Representatives from all supportive service programs fully participate in the HIV CQM committee. • Quality improvement projects routinely include and involve clinical and supportive service staff working on the QI team as evidenced in project documentation in storyboards or by other documentation that is shared with all stakeholders including consumers and staff of both supportive and clinical services. • Demonstrates sharing of data, QI projects, and resources to improve outcomes as evidenced in the annual HIV QM plan, CQM program meetings, and documented QI activities. • Performance measurement and QI data are communicated widely to staff and stakeholders throughout the program, transparently sharing progress on goals and improvement outcomes. • Ensures that data collected in supportive service programs are reviewed and integrated with clinical program performance measurement as evidenced in the annual HIV QM plan.
Comments:		

Summary of Results

What are the major findings from the Organizational Assessment?
Please number and link all findings with key recommendations and suggestions. Major findings should address all components especially those with – but not limited to - a score below 3.

What are the key recommendations and suggestions? What specific areas should be improved? What are specific improvement goals for the upcoming year?
Please include associated timeframe for each recommendation and improvement goal. Recommendations and areas in need of improvement should address all components of importance.

Comments By: _____ Date: _____

Program Information

HIV PROGRAM NAME: _____

Contact Person Name: _____

Contact Email/Phone: _____

Main Program Address: _____

City _____ State: _____ Zip Code: _____

Fax: _____

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

☐	*Site Name*	*HIV Caseload*	*City*	*State*	*Zip*
☐	*Site Name*	*HIV Caseload*	*City*	*State*	*Zip*
☐	*Site Nam*	*HIV Caseload*	*City*	*State*	*Zip*
☐	*Site Name*	*HIV Caseload*	*City*	*State*	*Zip*

Type of Facility
Select One
(for Part C and/or D funded):

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

Funding Source(s):
Check all that apply

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

On-Site Services:

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

HIV Care Delivery:

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

Staffing:

☐ FT HIV Medical Director ☐ FT HIV Administrator
☐ FT HIV Quality Manager If not FT, ____ % HIV Quality Manager

Regional Group/Learning Network/Collaborative Involvement	
Initiative Name	
Initiative Name	
Initiative Name	

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

Survey Completed: Name: Date:

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

Clinical Quality Management Plan Review Checklist

The clinical quality management (CQM) plan should address how the grant recipient will meet the key components of a CQM program as outlined in Clinical Quality Management Policy Clarification Notice (PCN) 15-02.

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

The table below lists each of the components of a CQM plan. Each component is highlighted based on the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP) expectations and includes descriptions of the narrative, resources and tips for each component.

Recipient: Date of Plan:	Date reviewed:	Division: Reviewer:	Part:

General Information		
Content	**Present: Yes/No/Partial**	**Comments**
Include the name of the grant recipient and the date last updated or approved.		
Quality Statement		
PCN 15-02	None	
Content	**Present: Yes/No/Partial**	**Comments**
• Include a statement that is brief, visionary, and related to HIV services.		

• Describe the ultimate goal of quality efforts and the purpose of the CQM program.		

Annual Quality Goals			
PCN 15-02	None		
Content		**Present: Yes/No/Partial**	**Comments**
• Outline year's priorities for the CQM program. • Include five or fewer measurable and realistic goals. • Describe endpoints/conditions towards which program work will be directed. • Focus on the program's most important areas of need with an emphasis on improvement.			

Quality Infrastructure			
PCN 15-02	• Utilization of RWHAP grant funds to establish an appropriate infrastructure for a CQM program is allowed. • An ideal infrastructure consists of the following: leadership, quality management committee, dedicated staffing, dedicated resources, CQM plan, people with HIV involvement, stakeholder involvement, and evaluation of the CQM program.		
Content		**Present: Yes/No/Partial**	**Comments**

Describe how leadership guides, endorses, and champions the CQM program.		
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.		
Describe the staff positions responsible for developing and implementing the CQM program and related activities including the role of contractors funded to assist with the CQM program.		
Describe who writes, reviews, updates, and approves the CQM plan.		

Describe how people with HIV are involved in the development and implementation of the CQM program.		
Describe how stakeholders (e.g., subrecipients, other recipients in the region, planning body/committee, etc.) provide input into the CQM activities.		
Describe how the effectiveness of the CQM program is evaluated.		

Performance Measurement	
PCN 15-02	• Recipients are strongly encouraged to include HRSA 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.

Content	**Present: Yes/No/Partial**	**Comments**
Describe how performance measures are selected and regularly reviewed for relevance, need, etc.		
Describe the process to collect performance measure data including engagement of subrecipients.		
Describe the process to analyze the performance measure data including stratifying the data to identify health disparities and sharing the data with stakeholders.		

Identify performance measures for all RWHAP-funded service categories, per PCN 15-02		
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 QI activities. • Recipients should conduct QI activities within at least one funded service category at any given time. (QI project may span multiple service categories.)	
Content	**Present: Yes/No/Partial**	**Comments**
Describe the QI approach or methodology used (e.g., Model for Improvement/PDSA, Lean, etc.).		
Describe how QI priorities or projects are selected; if known, state the QI priorities or projects for current year.		

Describe how QI projects are documented.		
Describe how subrecipients are engaged, supported, and monitored with respect to QI.		
Work Plan		
PCN 15-02 | None		
Content	**Present: Yes/No/Partial**	**Comments**
Provide a thorough overview of implementation: establish timelines, milestones, and accountability for all CQM program activities outlined in the CQM plan.		
Table format may be used to state goals with columns detailing objectives, key activities (milestones), timelines		

(target dates), responsible parties (accountability), and outcomes/impact.		
Describe how the work plan will be shared/communicated with all stakeholders (e.g., staff, people with HIV, board members, parent organizations, other recipients, funders, etc.).		

Plan-Do-Study-Act Cycle Sheet

QIP_____ **Cycle**_____

AIM	

Plan		
	• What changes are you testing with the PDSA cycle? • What do you predict will happen and why? • Who will be involved in this PDSA? • Plan a small test of change. • How long will the change take to implement? • What resources will they need? • What data needs to be collected?	**List your action steps along with person(s) responsible and timeline:**

Do		
	• Carry out the test on a small scale. • Document observations, including any problems and unexpected findings. • Collect data you identified as needed during the 'plan' stage.	**Describe what happened when you ran the test.**

Plan-Do-Study-Act Cycle Sheet

QIP _____ **Cycle** _____

Study

- Study and analyze the data.
- Determine if the change resulted in the expected outcome.
- Were there implementation lessons?
- Summarize what was learned.
- Look for: unintended consequences, surprises, successes, and failures.

Describe the measured results and how they compared to the predictions.

Act

Based on what was learned from the test:

- Adapt - modify the changes and repeat the cycle.
- Adopt - consider expanding the changes with a greater client pool
- Abandon - change your approach and repeat the PDSA cycle.

Describe what modifications to the plan will be made for the next cycle from what you learned.

Circle one:

Adapt **Adopt** **Abandon**

This template was adapted from the Center for Medicare and Medicaid PDSA Cycle Template that can be found at https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/pdsacycledebedits.pdf

RCA: FIVE-WHY'S WORKSHEET

Use the provided template to complete a 5-why's root cause analysis.

The Problem

What is the problem that your committee is trying to solve?

Why?

Why?

Why?

Why?

Why?

Why?
Root Cause

RCA: FIVE-WHY'S WORKSHEET

Use the provided template to complete a 5-why's root cause analysis.

Problem

First Why

Second Why

Third Why

Fourth Why

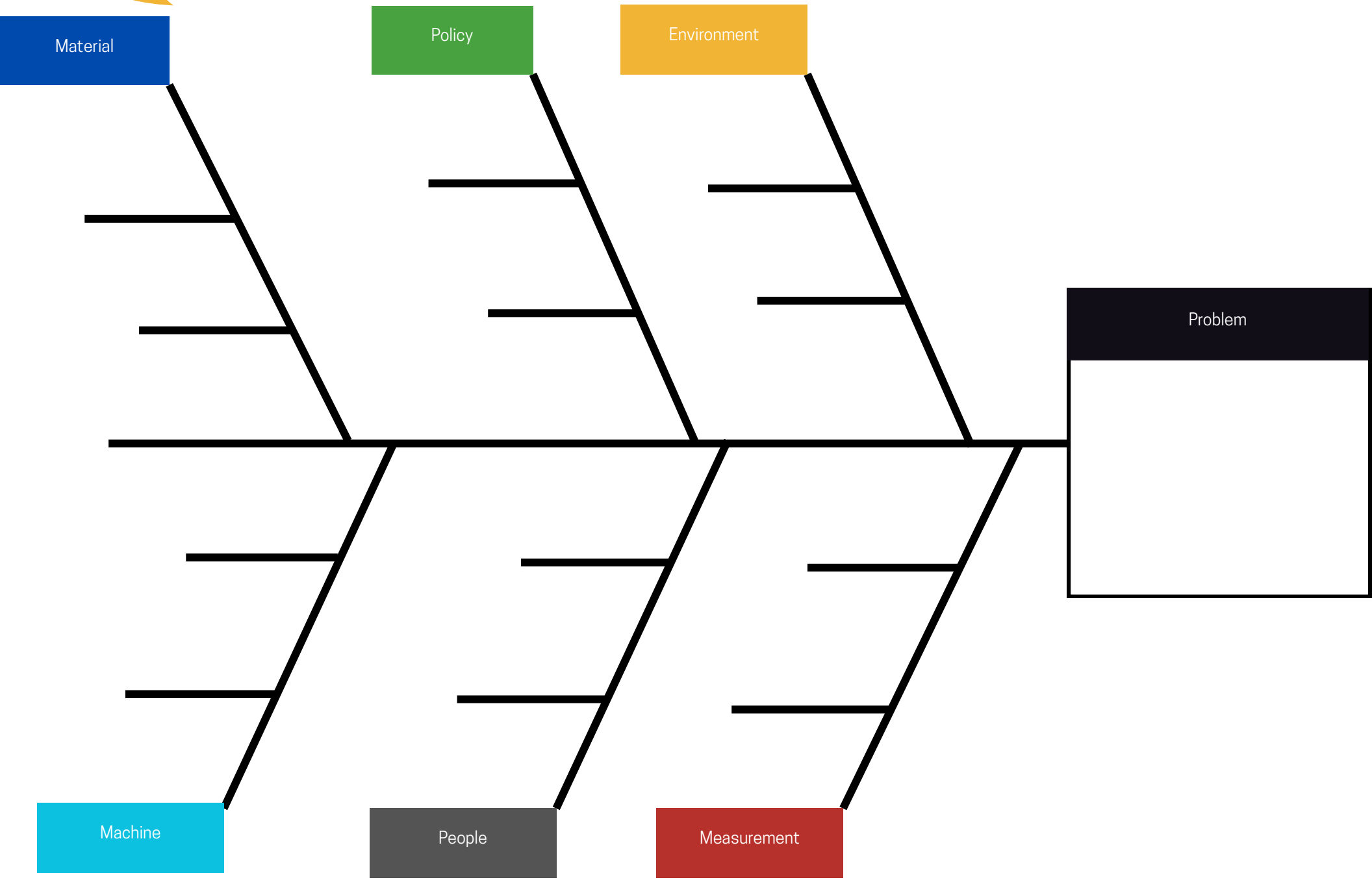
Fifth Why

Root Cause

Proposed Action

RCA: FISHBONE DIAGRAM

Fishbone Diagram template to reference. Recreate this on a whiteboard or flipchart.



A3 Report

Title:

Date Started: **Current Date:**

Name and Agency:

Team Members:

Executive Sponsor:

LEANOhio

P1: Why Change is Needed

P2: Current State

P3: Goals/Targets

P4: Analysis

P5: Potential Solutions

D6: Action Plan

Action item	Assigned to	Due Date

C7: Improvement Metrics

	Current	Projected	Actual
# Process Steps			
# Decision Points			
# Defects			
# Handoffs			
Lead Time			
Cust Satisfaction			

C8: Check Results

A9: Follow-up Action

Logo Here

Title

Name of Presenter, Associates & Collaborators

Agency Name & Year

Logo Here

Background

IN THIS SECTION YOU WOULD IDENTIFY YOUR PROBLEM STATEMENT AND ELABORATE WHY YOUR AGENCY DECIDED TO FOCUS ON THE AREA YOU DID FOR YOUR QI PROJECT

AIM Statement

[AGENCY]'S AIM STATEMENT

[NAME OF AGENCY] AIMS TO INCREASE [MEASURE] FROM [BASELINE] TO [GOAL] THROUGH [PROCESS] BY [DATE]

Measures

PROCESS MEASURES

What data did you use to ensure that your QI process was happening?

OUTCOME MEASURE

what data did you use to ensure that your QI process was working?

PDSA Cycles

CYCLE 1

Plan:
Do:
Study:
Act

CYCLE 2

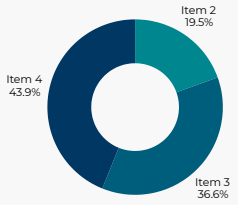
Plan:
Do:
Study:
Act

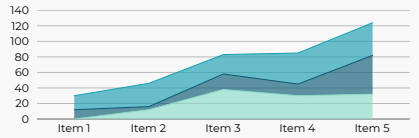
CYCLE 3

Plan:
Do:
Study:
Act

Results

DISCUSS THE RESULTS OF YOUR QI PROJECT USING THIS SPACE. PROVIDE GRPAHS OR CHARTS THAT WERE DEVELOPED BY YOUR QI TEAM TO ANALYZE THE DATA YOU COLLECTED.





EXPLANATION 1

Explain graph

EXPLANATION 2

Explain chart

Successes, Challenges & Next Steps

SUCCESSES

What went well/as planned?

CHALLENGES

What went wrong? Include barriers

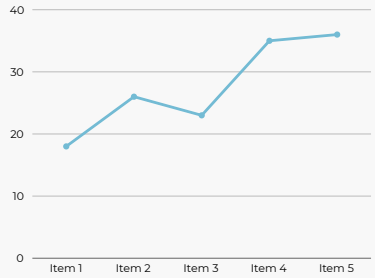
NEXT STEPS

How will you move forward form here?

Acknowledgements

THIS SECTION IS TO THANK ANYONE THAT CONTRIBUTED TO THIS PROJECT TO INCLUDE BUT NOT LIMITED TO AGENCY LEADERSHIP AND STAKEHOLDERS

Charts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Item 3
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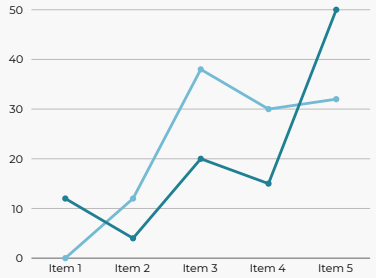
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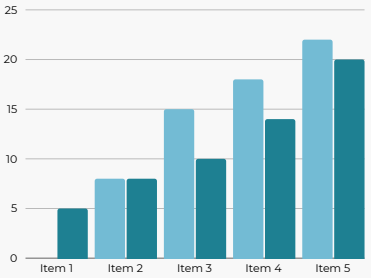
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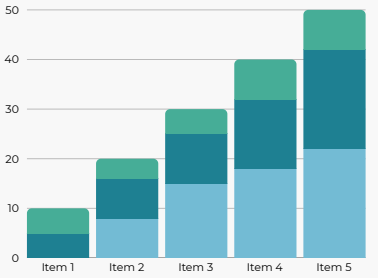
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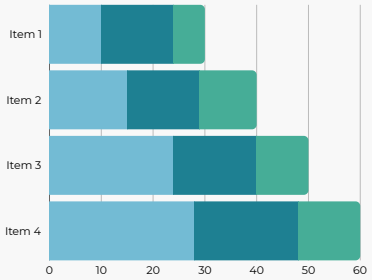
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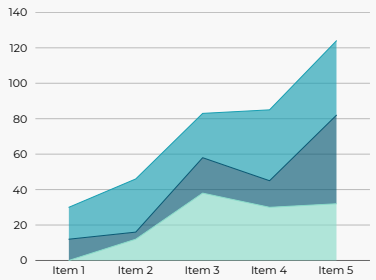
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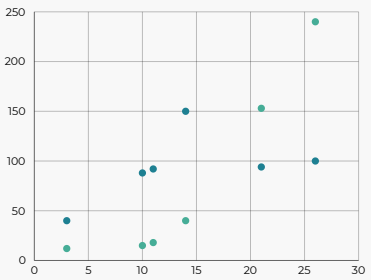
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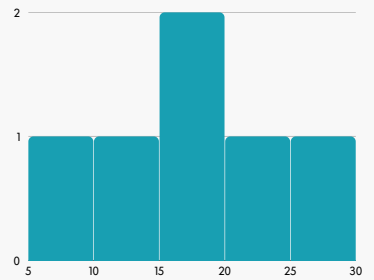
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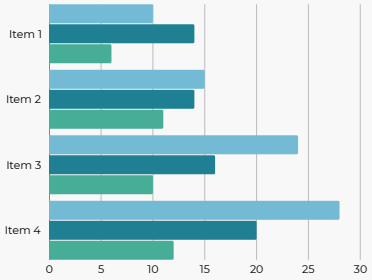
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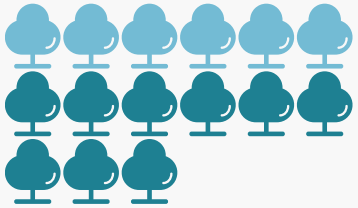

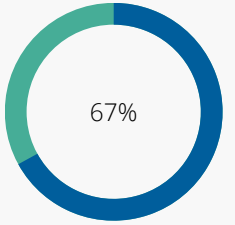
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Questions? Suggestions. Comments?

At Heart of Florida United Way we are always looking to ensure that the content created and supplied to our Area 7 subrecipient agencies continually adds value to the work that is carried out throughout Central Florida.

If there is anything in this document that you would like to have updated and/or additional sections, you would like added, please utilize the contact information below to reach out to the Clinical Quality Manager for the Area 7 Ryan White Part B program:

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407-429-2188

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Orlando, FL 32804