Austin **TRANSITIONAL GRANT AREA**

Ryan White HIV/AIDS Program – Part A

Clinical Quality Management Plan
Grant Year 2022/23

Reviewed July 14, 2022

COLLABORATIVE RESEARCH

Table of Contents

Introduction

The Austin Part A Transitional Grant Area (TGA)includes five counties: Bastrop, Caldwell, Hays, Travis, and Williamson. HOPWA serves the same five counties. The Part C program serves these counties plus five others that are part of the Ryan White Part B HIV Service Delivery Area (HSDA): Blanco, Burnet, Fayette, Lee, and Llano. Approximately two million people reside in the Austin TGA. Most of the TGA population is White (54%) followed by Hispanic (36%). African Americans make up 7% of the Austin TGA. At the end of 2020, there were more than 6930 residents living with HIV infection, with 222 new diagnoses that year. The largest city, Austin, lies in Travis County, where the majority (80%) of people with HIV (PWH) reside. The Clinical Quality Management Committee (CQMC) is established to guide the development of the clinical quality management program and participate in the continuous quality improvement activities for core medical and support services in the TGA. The CQMC will work with all RWHAP subrecipients to continuously improve the quality of care, service delivery, and health outcomes for people with HIV (PWH) in the Austin TGA, with a vision of *Ending the Epidemic.*

Quality Statement

The Clinical Quality Management Program (CQMP) of the Austin TGA is a coordinated, comprehensive, and continuous effort to monitor and improve the quality of care provided to PWH throughout the Austin TGA. The Austin HIV Resources Administration Unit (HRAU), Clinical Quality Management Coordinator, will assist in developing strategies and assisting in monitoring Clinical Quality Management (CQM) activities to ensure that service delivery to all RWHAP eligible PWH is equitable and adheres to the National HIV/AIDS Strategy, National Monitoring Standards, HIV clinical practice standards, Public Health Service guidelines, and the HRSA/HAB RWHAP Program Letters.

The following components are vital to the success of the Austin TGA CQMP. These components will ensure that service delivery is effective and equitable for RWHAP eligible PWH in the Austin TGA:

- **Infrastructure**: the backbone of a CQM program, detailing the roles of the CQMC, HRAU staff, HRAU subrecipients, RWHAP consumers, and stakeholders, and evaluation of the CQM program.
- **Performance Management**: the process of collecting, analyzing, and reporting data regarding patient care, health outcomes on an individual or population level, and patient satisfaction.
- **Quality Improvement**: the development and implementation of activities to make changes to service delivery in response to the performance-driven results.

The purpose of the CQMC is to:

- Demonstrate a commitment to continuous quality improvement throughout the TGA;
- Assist in describing the TGA's CQM program and CQM committee infrastructure;
- Identify strategic activities for quality improvement;
- Guide the development of structured activities that will enhance service delivery to RWHAP eligible PWH in the TGA; and
- Communicate the roles, responsibilities, and expectations of the CQM committee, HRAU staff, HRAU subrecipients, RWHAP consumers, and stakeholders.

Annual Quality Goals

The Annual Quality Management Plan outlines how the CQM program will be implemented for the current calendar year, including a clear indication of roles, responsibilities, accountability, performance measurement strategies, annual quality goals, a workplan, a timeline for quality activities, data collection strategies, reporting mechanisms, and the elaboration of processes for ongoing evaluation and assessment of the program. The CQM committee and designated Single Points of Contacts (SPoCs) from each subrecipient will guide the review, revision, and implementation of the annual quality management plan. The final approval will be granted by the HRAU Clinical Quality Management Coordinator.

- **Goal 1:** Promote continuous quality improvement initiatives across the TGA.
- **Goal 2:** Improve the quality of core medical and support services provided by TGA.
- **Goal 3:** Improve the performance measurement system to appropriately assess outcomes for PWH.
- **Goal 4:** Ensure the comprehensive involvement of PWH in the quality improvement process.

Quality Infrastructure

The Austin TGA CQM program operates through both a HRAU internal CQM committee and an external Clinical Quality Management Committee (CQMC). The internal CQM committee is comprised of those responsible for planning, reporting, and supporting the activities that relate to the CQM plan. The HRAU internal CQM committee consists of the HRAU Program Manager, Grants Program Manager, Clinical Quality Management Program Coordinator, Part A Business Specialist, and Part A Grants Coordinators. The frequency of the HRAU internal committee meeting is held on a monthly basis. The HRAU internal CQM committee is responsible for the following list of activities:

- **Actively participate in meetings, conference calls, and other activities, as needed.**
    - Participate in capacity building and training activities.
- **Strategic planning through:**
    - Review core performance measures at least quarterly.
    - Discuss system-wide CQI issues / challenges to develop strategies to improve care
- **Initiate meetings to address:**
    - Chart reviews and outcome measure reports and other relevant data
    - Review and revise assessment and data collection tools, protocols, and processes as necessary.
    - Allocate resources needed to implement quality projects.
    - Review and update the CQM Plan annually
    - Provide input on annual evaluation of the CQM program
    - Support CQM initiatives across other programs and promote buy-in with Subrecipients
    - Provide insight in current HIV care delivery issues or barriers to care they identified.

Additionally, the CQM Program operates through the Clinical Quality Management Committee (CQMC) which receives guidance and support from the Austin HRAU. Participation of subrecipients receiving funding from the RWHAP program is required. Input is received from all RWHAP subrecipients, in addition to RWPA Planning Council, PWH receiving RWPA services, and non-RWHAP funded community partners. Priorities are established in concert with the RWPA Planning Council and aligned with Policy Clarification Notice (PCN) #15-02.

The purpose of the CQMC is to establish a mechanism where RWPA subrecipients can coordinate efforts and demonstrate improvement in service delivery and performance measure outcomes. The need for technical assistance, capacity building, and training opportunities are assessed and provided as appropriate to further the CQM program goals and objectives. The efforts of the Austin TGA CQM program contribute to the improvement of health outcomes for RWPA eligible PWH in the TGA, ensure that service delivery is equitable, and adheres to the National HIV/AIDS Strategy, National Monitoring Standards, HIV clinical practice standards, Public Health Service guidelines, and the HRSA/HAB RWHAP Program Letters.

Clinical Quality Management Committee		
Representative	**Role**	**Responsibilities**
Ryan White Part A **Ken Martin**	Austin HRAU Program Manager	• Endorses, champions, and promotes the CQM program • Provides leadership and support to the CQM program • Approves CQM Plan • Approves quality improvement and PDSA activities • Provides guidance directed at policies, procedures, and the compliance component of the CQI program • Reports CQM activities to HRSA/HAB, Subrecipients, Planning Council, and Community Partners • Coordinates technical assistance and training
Ryan White Part A Jennifer La Blanc	Austin HRAU Clinical Quality Management Coordinator	• Attends all CQM committee meetings • Chairs and oversees the CQM committee • Leads the CQM Committee • Endorses, champions, and promotes the CQM program • Provides leadership and support to the CQM program • Approves CQM Plan • Conducts organizational assessments of Subrecipients • Approves quality improvement and PDSA activities • Tracks outcomes of quality improvement activities and PDSAs • Provides guidance directed at policies, procedures, and the compliance component of the CQI program • Reports CQM activities to HRSA/HAB, Subrecipients, Planning Council, and Community Partners • Coordinates technical assistance and training

Ryan White Programs Ken Martin	Austin HRAU Grants Program Manager	• Attends all CQM committee meetings • Approves CQM Plan in coordination with the CQM Coordinator • Assesses existing programs for improvement needs relative to RWHAP CQM requirements such as improved client services and improved health outcomes • Reviews program objectives and conducting literature and program research related to Quality Improvement (QI) activities • Analyzes health outcome and other data to identify desirable improvements • Works with the QM Coordinator to identify QI projects that respond to the needs of People Living With HIV (PLWH) in the jurisdiction; acting as Lead for agreed-upon QI projects • Participates QM Leadership Team meetings and planning • Troubleshoots CQM challenges with the QM Coordinator
Ryan White Part A Sherry Lyles	Austin HRAU Business Process Specialist	• Attends all CQM committee meetings • Provides statistical reports that consist of tracking clinical outcomes to support CQM committee and quality improvement activities • Collaborates with the Recipient and CQM Consultant to track and extract performance measures to identify performance variance, root causes of underperformance, and areas that fall short of QI • Providers training to Subrecipients on CQM and QI reports in TCT
Ryan White EHE **Raju Ghimire, PhD.**	Austin HRAU Research Analyst	• Attends all CQM committee meetings • Provides statistical reports that consist of tracking clinical outcomes to support CQM committee and quality improvement activities • Collaborates with the Recipient and CQM Consultant to track and extract performance measures to identify performance variance, root causes of underperformance, and areas that fall short of QI • Providers training to Subrecipients on CQM and QI reports in TCT

Ryan White A Erin Brown	Austin HRAU RWPA Grants Coordinator	• Attends all CQM committee meetings • Collaborates with RWPA to align and leverage community-wide efforts • Share resources, knowledge, and expertise by providing input on CQM activities • Requests data from State HIV Surveillance, Office of Public Health and Epidemiology Program
Collaborative Research Thomas Rodriguez-Schucker Michael Koran	CQM Consultant Committee Member	• Attends all CQM committee meetings • Coordinates and facilitates the CQM committee • Drafts and updates the annual CQM Plan • Assists in the organizational assessments of subrecipients • Assists in developing quality improvement activities • Assists in tracking outcomes of quality improvement activities and PDSAs • Disseminates programmatic activities and data • Coordinates Basecamp activities • Provides leadership and support to the CQM program • Provides guidance in the selection and implementation of Quality Improvement projects based on trends and needs of the service delivery system • Assists in the coordination of technical assistance and training • Posts CQM agenda, meeting minutes, and resources to the website
Part A Consumers	Committee Member	• Attends all CQM committee meetings • Provides guidance to the annual CQM plan • Provides guidance for TGA-wide Quality Improvement projects • Participate in consumer satisfaction surveys • Actively participates and collaborates as a consumer of services • Disseminates CQM and QI activities to the community • Participates in mandatory CQM and QI training
Part A Subrecipients Shondrea Harroon**, Community Care Texas,** Todd Logan**, Project Transitions** Emily Johnston**, Integral Care** Stacey Martinez**, Community Action** Sandra Najuna**, Aids Health Foundation,**	Committee Member; Single-point-of-contact (SPoC)	• Attends all CQM committee meetings • Provides guidance to the annual CQM plan • Participates in the annual organizational assessment for CQM • Provides guidance for TGA-wide Quality Improvement projects • Accountable for entering current and consistent, service data for collection and reporting purposes • Conducts consumer satisfaction surveys to measure the impact of the RWPA Program • Actively participates and collaborates as subject matter experts on the CQM Committee

Aubrey Braglia, **Vivent Health** Sandra Chavez, **Ashwell** Matt Phebus, **Kind Clinic**		• Involved in day-to-day activities related to quality improvement projects and PDSA's in a proactive manner • Meets contract deliverables, participates in conducting PDSA cycles • Develop and tracks quality improvement projects as well as reports to the CQM committee and Recipient • Disseminates CQM and QI activities to agency staff • Participates in mandatory CQM and QI training • Presents PDSA findings and outcomes when appropriate to the CQM committee
Ryan White Part B **Kristi Hanle, BVCOG**	Committee Member	• Attends all CQM committee meetings • Collaborates with RWPA to align and leverage community-wide efforts • Share resources, knowledge, and expertise by providing input on CQM activities • Requests data from State HIV Surveillance, Office of Public Health and Epidemiology Program
Ryan White Part C Tara Hinojosa	Austin HRAU RWPC Grants Coordinator	• Attends all CQM committee meetings • Collaborates with RWPA to align and leverage community-wide efforts • Share resources, knowledge, and expertise by providing input on CQM activities • Requests data from State HIV Surveillance, Office of Public Health and Epidemiology Program
HOPWA Recipient Julia Herrera	HOPWA Program Analyst Committee Member	• Attends all CQM committee meetings • Collaborates with RWPA to align and leverage community-wide efforts • Share resources, knowledge, and expertise by providing input on CQM activities • Provide outcomes of the HOPWA program

Community Stakeholders		
Stakeholder	**Role/Participation**	**Task(s)**
Part A Planning Council	• Reviews and utilizes data for Planning Council Activities • Reports as part of the priority setting and resource allocation • Identifies areas for improvement • Provides and periodically updates of service standards for the TGA • Reviews and utilizes service data and reports • Uses quality management data in decision making	• Data Reports: service utilization, epidemiological, cost utilization, performance measure outcomes, and quality assurance outcomes • Research best practices and work done by other/similar TGAs • Conduct needs assessments • Act as the voice of consumers in service delivery

AIDS Education and Training Center (AETC)	• Education and training	• AETC provides targeted, multidisciplinary education and training programs for healthcare providers, including presentations on updated clinical guidelines, information, on new pharmaceuticals and chronic disease management
Community Members	• Provide community input	• Attends all CQM committee meetings • Participate in surveys and needs assessments • Disseminates CQM and QI activities to the community

Evaluation

The Austin HRAU Clinical Quality Management Coordinator, Program Manager, HRAU Grants Manager, and CQM Consultant will evaluate and update the CQM plan bi-annually with the guidance and support from the Austin TGA CQM Committee and community stakeholders.

To evaluate efforts, the CQM Consultant collects and analyzes both qualitative and quantitative methods of data. Subrecipients share descriptive qualitative data as a method of inquiry to provide context and a better understanding of what type of care is provided as well as how care is provided to inform health care practices.

Single-points-of-contact (SPoCs) from each agency complete a Quality Improvement Worksheet *(Appendix A)*, which includes the Plan, Do, Study, Act (PDSA) process to document and evaluate quality improvement activities and PDSA cycles on a biannual basis. The PDSA method is a way to test a change that is implemented. Going through the prescribed steps guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again.

The committee also produces an annual report of the monitored performance measures and compares the data to the TGA's benchmarks and goals or predicted outcomes. Collectively, committee members share what was learned during the PDSA cycle by sharing successes and challenges, including best practices. If the subrecipient is not satisfied with the outcomes of the quality improvement project, opportunities to adjust and repeat a project will be available at the next quality improvement and PDSA cycle.

Communication and Dissemination

The QM Team believes that the sharing of information serves to strengthen our partnerships within the community and helps to provide services more efficiently to people affected by HIV. Reliable data and consistent communication are important because they provide transparency and accountability regarding what services are being offered and the effectiveness of those services. The QM Team ensures that each stakeholder listed below is provided the relevant education/training, as necessary, to understand the information and data that is disseminated by the RWPA Program.

OUTLINE OF REGULAR QUALITY MANAGEMENT COMMUNICATIONS

Information	Stakeholders	Frequency	Communication Methodology
CQM Plan	Recipient RW Part B RW Part C HOPWA CQM Committee Planning Council Community Stake Holders	At least annually *(As needed)*	• CQM Committee presentation • Planning Council presentation • TGA website publication • Basecamp publication
Service Standards	Recipient CQM Committee Planning Council Community Stake Holders	At least annually *(As needed)*	• CQM Committee presentation • Planning Council presentation • TGA website publication
Service-specific Outcome Reports	Recipient RW Part B RW Part C HOPWA CQM Committee Planning Council Community Stake Holders	Quarterly	• CQM Committee presentation • TGA website publication • Basecamp publication
Annual Site Reviews	Recipient CQM Committee Planning Council Community Stake Holders	At least annually	• CQM Committee presentation • Planning Council presentation • TGA website publication
Monthly Service Reports	HRSA Project Officer	Monthly	• Quantitative and narrative reports
CQM Bulletins	CQM Committee	Monthly	• Monthly communication containing updates and meeting information

Performance Measurement

Performance measurement is the systematic collection and analysis of data. A successful program translates into viral suppression. Performance measures are required, at minimum for any Service Category utilized by 15% or more of clients in the Austin TGA. Performance measures shall be defined by the Recipient and included in contracts for subrecipients funded to provide these services that meet this criterion to ensure that the TGA is meeting the minimum required Performance Measures per funded service category as prescribed in Policy Clarification Notice (PCN) 15-02.

The CQM Committee and SPoCs collect and analyze performance measurement data to review and discuss the performance measurement status and progress with the CQM committee members and stakeholders. The Austin TGA is currently monitoring the following service categories: LPAP, Early Intervention Services, Health Insurance Premium and Cost Sharing Assistance, Medical Case Management, Medical Nutrition, Mental Health, Oral Health, Outpatient Ambulatory Health Services, Substance Abuse- Outpatient, Emergency Assistance, Food Bank, Housing Services, Medical Transportation, Non-Medical Case Management, and Substance Abuse-Residential. Because a successful program translates into viral suppression, “support service”

agencies will also monitor their clients' viral suppression. The CQM committee will use the performance measurement data to identify, stratify, and prioritize QI projects and goals.

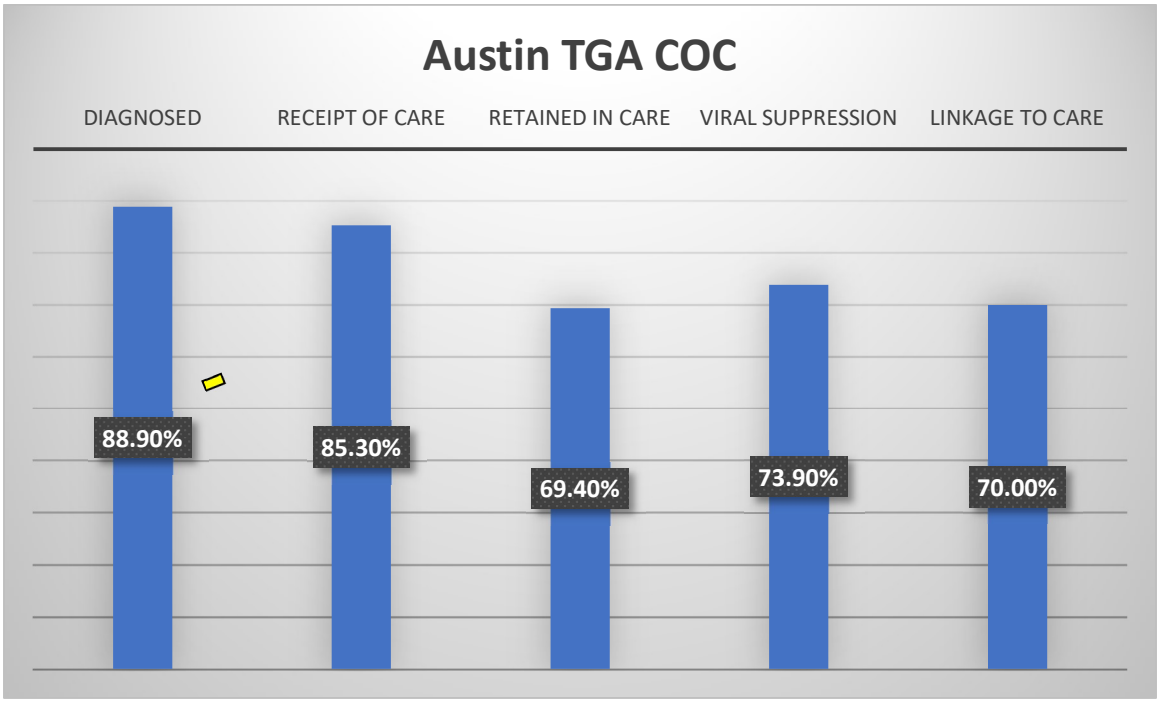
Updated requirements per PCN 15-02	
Percent of RWHAP eligible clients	Minimum # of performance measures
>=50%	2
>15% to <50%	1
<=15%	0

Service Category	Total Eligible Clients	Denominator	Numerator	Performance Score	Number of Measures
AIDS Pharmaceutical Assistance Program - Local	2295	2295	701	31%	1
Early Intervention Services	2295	2295	10	0.4%	0
Emergency Financial Assistance	2295	2295	150	7%	0
Food Bank/Home Delivered Meals	2295	2295	580	25%	1
Health Insurance Premium and Cost Sharing Assistance	2295	2295	139	6%	0
Housing Services	2295	2295	13	1%	0
Medical Case Management, including Treatment Adherence Services	2295	2295	179	8%	0
Medical Nutrition Therapy	2295	2295	95	4%	0
Medical Transportation Services	2295	2295	302	13%	0
Mental Health Services	2295	2295	108	5%	0
Non-Medical Case Management	2295	2295	489	21%	1
Oral Health Services	2295	2295	960	42%	1
Outpatient /Ambulatory Health Services	2295	2295	921	40%	1
Substance Abuse Services - Outpatient	2295	2295	85	4%	0
Substance Abuse Services - Residential	2295	2295	4	0.2%	0

Source: TCT & Closeout Reports, GY2021/2022

The RWPA Program adheres to the definitions for the HIV Care Continuum. Those definitions are, as follows:

- HIV-Diagnosed – Numerator: The number of persons, aged over 13, with a diagnosed HIV infection in the jurisdiction at the end of the calendar year. Denominator: Number of persons, aged over 13, with HIV infection (diagnosed or undiagnosed) in the jurisdiction at the end of the calendar year.
- Receipt of Care- Numerator: The number of persons, aged over 13, with diagnosed HIV infection, who had a care visit during the calendar year, as measured by documented test results for CD4 count or viral load. Denominator: Numbers of persons, aged over 13, with HIV infection diagnosed by previous year end and alive at year end.
- Retained in Care-Numerator: Number of persons, aged over 13, with diagnosed HIV infection who had two care visits that were at least 90 days apart during a calendar year, as measured by documented CD4 count or viral load. Denominator: Number of persons, aged over 13, with HIV infection diagnosed by the previous year-end and alive at year end.
- Viral Suppression- Numerator: Number of persons, aged over 13, with diagnosed HIV infection who's most recent viral load test during the calendar year showed that HIV viral load was suppressed. Viral suppression is defined as a viral load test result of <200/mL at most recent viral load test. Denominator: Number of persons, aged over 13, with HIV infection diagnosed by the previous year-end and alive at year end.
- Linkage to Care-Numerator: Number of persons, aged over 13, with newly diagnosed HIV infection during the calendar year who were linked to care within one month of their diagnosis date as evidenced by a documented test result for a CD4 count or viral load. Denominator: Number of persons, aged over 13, with newly diagnosed HIV infection during the calendar year.



Austin TGA COC 2022		
Diagnosed: Percentage of persons aged over 13 with HIV infections who know their serostatus	6,708	88.9%
Receipt of Care: Percentage of people with diagnosed HIV infection who had at least one CD4 or viral load test during the calendar year	5,719	85.3%
Retained in Care: Percentage of person with diagnosed HIV infection who had at least two CD$ or viral load tests performed at least 90 days apart with the calendar year	4,656	69.4%
Viral Suppression: Percentage of persons diagnosed with HIV infection who's most recent HIV viral load test in the last 12 months showed that HIV viral load was suppressed	4,959	73.9%
Linkage to Care: Percentage of persons with newly diagnosed HIV infection who were linked to care within one month after diagnosis as evidenced by a documented CD4 count or viral load	172	70%

Source: DSHS, 2020

Quality Improvement

The Austin HRAU Clinical Quality Management Coordinator, Program Manager, HRAU Grants Manager, and CQM Consultant will work with subrecipients to build capacity and provide guidance on prioritizing measures and data collection to identify improvement opportunities and monitor QI activities.

The Austin TGA SPoCs will use the Plan, Do, Study, Act (PDSA) model for improvement to learn and build knowledge and expertise over time as they design a change that will result in improvements. The results from evaluations are used to reevaluate, build, or expand successful activities. If subrecipients have difficulty meeting goals, barriers are addressed, and one on one training is provided. All steps of quality improvement projects are documented by subrecipients on the Austin TGA Quality Improvement Project Worksheet. *(Appendix A)*

The PDSA Methodology is widely utilized in human service fields and is identified as a preferred option by HRSA for RWHAP. The PDSA steps are:

1. **Plan** – Develop an objective with questions and predictions
2. **Do** – Carry out the plan on a small scale and document the process
3. **Study/Check** – Analyze the data, compare it to the "Plan" section and document process

4. **Act** – Adapt the new process, abandon it, or revise and begin the cycle again

System-wide quality improvement activities include: the improvement of data collection techniques/tools, organizational assessments of the RWPA and subrecipient QM programs, and distribution of needs assessment/client satisfaction results. The Recipient and CQM Recipient work with individual subrecipients to develop and implement QI initiatives, including agency-specific outcome goals. Following the Plan-Do-Study-Act (PDSA) model, subrecipients are required to identify areas of improvement, perform subsequent PDSAs to address identified concerns or target populations, and present findings, challenges, and implementation plans to the CQM Committee on a biannual basis.

Client Satisfaction Surveys
Per Ryan White Program Administration policy, recipient are required to collect client satisfaction information annually. Recipients must include, at a minimum, questions that
assess each of the service categories they are funded to provide. The survey should be appropriately worked to elicit potential barriers to access, cultural competency, and quality. This can include, for example:
• General satisfaction,
• Client participation,
• Perceived outcomes,
• Continuity of care,
• Effectiveness or result of service,
• Timeliness of care, and/or
• Customer service/staff skills.

The **External CQM Committee** will receive a report of activities related to collection of Client Satisfaction information. Results of surveys and any other relevant documentation will be attached to the report. The **External CQM Committee** will review the client satisfaction data and will use any relevant information collected from the surveys for quality improvement efforts.

The goal of the CQM program is to ensure that PWH in the TGA receive the highest quality core and supportive services. To accomplish this, the CQM Committee will ensure:

- Direct service medical subrecipients adhere to established practice standards, NPHPS Guidelines and Planning Council expectations to the extent possible;
- HIV-related supportive services focus on retention in care and viral load suppression as defined by the Care Continuum;
- Demographic, clinical and health care utilization information, as well as available health outcomes data and performance measures, are used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic;
- The existing CQM infrastructure and CQM plan are updated at least annually and on an as-needed basis;
- Technical assistance is provided to subrecipients in the development, implementation, and maintenance of their quality improvement projects;
- Compliance with HRSA/HAB National Monitoring Standards and PCN 16-02;
- Participation in the Recipient's chosen process for consumer satisfaction surveys; and
- QI data is collected, maintained, analyzed, and shared with appropriate stakeholders through publication, presentation, or other appropriate formats.

An overview of the Quality Improvement activities that the CQM Committee has identified is in the table below. The table serves as a living document, containing the current and future QI activities. Updates, revisions, and additions to this table are expected as health outcomes and performance measurement data are reviewed on a quarterly basis and will inform the activities herein. The table consists of six (6) categories that are used to track the progress of each QI activity, beginning with the overall **Goal** for each activity. The next column contains the current **Status** for each activity, indicating whether it's ongoing (a continuous activity), progressing (activity in motion), pending (planned for future) or completed. High-level objectives for each activity are listed within the **Actions Steps** section. The **Target Date** section outlines proposed dates for the accomplishment/completion of each activity, while the **Responsible** section lists which CQM Committee member(s) are tasked with overseeing each activity. Finally, any applicable **Resolution Notes** are included in the table for the corresponding activity.

Work Plan

Goal	Status Complete In Process In Planning / Future Delayed	Action Steps (at Plan onset)	Target Date	Responsible	Resolution Notes
Biannual review and update the TGA's QM Plan.	In Process: • GY22 Update Plan 7/14/2022 – Reviewed • GY23 Update FUTURE March 2023 – To be updated • GY23 Update – FUTURE August 2023 – To be updated	1. The Recipient and CQM Consultant present the CQM Committee with the updated GY22 plan for review. 2. The CQM Committee will review the plan and make proposed changes at the August 2022 meeting. 3. The CQM Committee will present to the Recipient a finalized plan by the end of the August 2022 meeting. 4. The Recipient will review and endorse the final plan.	July 2022 August 2022 August 2022 September 2022	Recipient CQM Consultant CQM Committee	Please being presented to the CQM Committee on July 14, 2022
Subrecipient SPOC to submit Quality Improvement Worksheets to Recipients and CQM consultant for review and approval.	Complete • QI Worksheets due by August 2022 CQM Meeting	1. Quality Improvement Worksheet to be completed by Subrecipient by the August 2022 CQM Committee meeting.	8/2022 9/2022	Recipient CQM Consultant SPOCs CQM Committee	All QI/PDSA cycle to begin in September 2022.
Conduct reviews of Subrecipient quality improvement initiatives/PDSAs.	Complete • Recipient and CQM to complete review by September 2022.	1. Recipient and CQM Consultant to review Quality Improvement Worksheets by the September 2022 meeting. 2. SPOCs to present QI Projects/PDSAs at the October 2022 CQM Committee meeting	9/2022	Recipient CQM Consultant SPOCs CQM Committee	All QI/PDSA presented to the CQM committee in October 2022.
SPOCs to present Continuum of Care Dashboard at each CQM Committee meeting.	Future: SPOC to present Continuum of Care Dashboard at each CQM Committee meeting Sept 2022, Oct 2022, Nov 2022, Dec 2022, Jan 2023, Feb 2023	1. SPOC to present CoC Dashboard at each meeting.	Sept 2022 Oct 2022 Nov 2022 Dec 2022 Jan 2023 Feb 2023	Recipient CQM Consultant SPOCs CQM Committee	RDE to provide training on CoC Dashboard for SPOCs.

Review outcomes of QI/PDSA for each Subrecipient. SPOC to present outcomes data to the CQM.	Complete • SPOC to present QI/PDSA outcomes to the CQM Committee at the February meeting.	1. SPOC to present QI/PDSA outcomes to the CQM Committee. 2. SPOC to submit Complete Quality Improvement project worksheets to the Recipient and CQM Consultant to close out the project.	March 2023	CQM Leadership QM Contractor QM Committee	Provide TA to SPOC on QI/PDSA outcomes as needed.
Subrecipient SPOC to submit Quality Improvement Worksheets to Recipients and CQM consultant for review and approval.	In Planning: • QI Worksheets due by March 2023 CQM Meeting	1. Quality Improvement Worksheet to be completed by Subrecipient by the February 2023 CQM Committee meeting.	February 2023	Recipient CQM Consultant SPOCs CQM Committee	All QI/PDSA cycle to begin in March 2023.
Conduct reviews of Subrecipient quality improvement initiatives/PDSAs.	Future: • Recipient and CQM to complete review by March 2023.	1. Recipient and CQM Consultant to review Quality Improvement Worksheets by the February 2022 meeting. 2. SPOCs to present QI Projects/PDSAs at the March 2023 CQM Committee meeting	March 2023	Recipient CQM Consultant SPOCs CQM Committee	All QI/PDSA presented to the CQM committee in March 2023.
SPOCs to present Continuum of Care Dashboard at each CQM Committee meeting	Future: SPOC to present Continuum of Care Dashboard at each CQM Committee meeting March 2023, April 2023, May 2023, June 2023, July 2023	1. SPOC to present CoC Dashboard at each meeting.	March 2023 April 2023 May 2023 June 2023 July 2023	Recipient CQM Consultant SPOCs CQM Committee	RDE to provide training on CoC Dashboard for SPOCs.
Review outcomes of QI/PDSA for each Subrecipient. SPOC to present outcomes data to the CQM.	Future: • SPOC to present QI/PDSA outcomes to the CQM Committee at the August 2023 meeting.	1. SPOC to present QI/PDSA outcomes to the CQM Committee. 2. SPOC to submit Complete Quality Improvement project worksheets to the Recipient and CQM Consultant to close out the project.	August 2023	CQM Leadership QM Contractor QM Committee	Provide TA to SPOC on QI/PDSA outcomes as needed.

Capacity Building

The Austin HRAU Clinical Quality Management Coordinator, Program Manager, HRAU Grants Manager and CQM Consultant will share relevant resources, webinars, articles, and success stories with the CQM committee, consumers, and stakeholders. Resources include information from the Center for Quality Improvement and Innovation (CQII) center, HRSA/HAB, Target HIV website, AIDS Education and Training Center and other recognized organizations in HIV care. CQM resources may address quality improvement topics or topics emphasizing gaps in care. In addition, the Recipient and CQM Consultant creates resources to build capacity, engage the community, and provide support to subrecipients. The CQM Committee also utilizes Basecamp to assist in project management. All CQM Committee members have access to Basecamp. Basecamp is a web-based project management software that includes tools for the CQM team to work together which includes message boards, to-dos, schedules, docs, file storage, real-time group chat, and automatic check-in questions.

Subrecipients will use Basecamp to submit quality improvement worksheets, data sets, report QI project data, and outcomes. The Recipient and CQM Consultant will also provide technical assistance to subrecipients on an as-needed basis. The two types of technical assistance provided will consist of direct in-person technical assistance and training or electronic technical assistance and training. The CQM committee believes that sharing information provides transparency and serves to strengthen partnerships within the community.

Austin HIV Resources Administration Unit (HRAU)
Ryan White Part A Program
Clinical Quality Management Committee

QUALITY IMPROVEMENT PROJECT WORKSHEET

Subrecipient: _____ **Project Period:** _____

CQM PROJECT STAFF		
Type:	Name:	Email Address:
PRIMARY		
SECONDARY		
Additional		
Additional		
Additional		

PROJECT DETAILS					
PROJECT TITLE:					
PROJECT START DATE:		**PROJECT END DATE:**		**PROJECT LOCATION:**	
PROBLEM:					

A concise description of the issue to be addressed. It should identify the gap between the current (problem) state and desired (aim) state of a process or system. You may wish to use the '5Ws' framework for capturing the problem statement: Who, What, When, Where, and Why.

Questions	Example Responses
What is the problem?	Check sheets are not being completed
Who does this affect?	Registered nurses
How does this problem make you feel?	Frustrated, stressed
When is it a problem?	Every time the day shift nurses sit down to do their reporting.
What should I care?	When the check sheets are not completed the nurses have to spend time searching for the information.
How does it affect the customer?	When the nurses don't have the information they have to search for it which takes away time that they could be spending with patients.

AIM:	

When constructing an aim statement, consider the following points: • *The system: the system to be improved (scope, boundaries, patient population, processes to address, providers, beginning and end, etc.)* • *Specific numerical goals for outcomes – ambitious but achievable* • *Includes timeframe (how good by when?)* • *Why does it matter to the service user, staff, or customer? Is there a story?* • *Can you connect your project aim to your agency's strategic plan?* • *Is there an economic argument?*	*Example:* ***Good aim statement**: By December of 2022, we will increase VL suppression on the Care Continuum Dashboard to 78%.* ***Bad aim statement**: We aim to reduce harm and improve patient safety for all of our internal and external customers.*

RATIONALE:	

The set of reasons for addressing the problem. This should include why addressing the problem now is important. It may be useful for reasons to cover the benefits that may result for patients, staff, internal operations, and finances. The stronger the rationale for addressing the problem now the more likely it is to secure support.

DRIVER DIAGRAM

	PRIMARY DRIVERS:	SECONDARY DRIVERS:	CHANGE IDEAS
AIM: *(From Above)*	**1.**		•
	2.		•
	3.		•
AIM: *By December of 2022, we will increase VL suppression on the Care Continuum Dashboard to 78%.*	**PRIMARY DRIVERS:** **1. Increase training and education on the e2BP system**	**SECONDARY DRIVERS:** **1a. Require refresher training** **1b. Require new staff training** **1c. Training schedule**	**CHANGE IDEAS:** • **Work with the AETC to provide mandatory training** • **Work with RDE to provide e2 training** • **Schedule time for training** • **Document staff training**
	2. Decrease the number of clients with missing data components	**2a. CCD Reports** **2b. Compliance checks** **2c. Internal audits**	• **Supervisors identify missing data elements biweekly** • **Data reports are provided to staff** • **Document internal audit processes** • **Increase communications with clients** • **Incorporate daily e2Reports**

	3. Increase the frequency of lab results for clients	**3a. Increase contact with the client** **3b. Develop client reminders**	• **Ensure clients are completing labs every 6-months** • **Encourage the use of e2MyHealth** • **Develop a client reminder system** • **Increase communications with clients** • **Incorporate daily e2Reports**

PLAN, DO, STUDY, ACT CYCLE	
PROJECT TITLE:	
AIM:	
Describe the objective of this PDSA cycle to give it a specific focus. The objective should be specific to the cycle but may draw on one or more of the following types of objective: • *Provide evidence that this change will result in an improvement;* • *Decide which of several potential changes will result in the desired improvement;* • *Assess how much improvement we can expect from this change;* • *Decide how to adapt a proven change to your environment;* • *Assess the cost impact and any side-effects of this change.*	
CHANGE IDEA:	
Although it's not required, all PDSAs should be linked to a change idea from your driver diagram.	
OVERVIEW NOTES:	
Describe your plan for carrying out this PDSA cycle. This should be detailed, but specifics around the different tasks should be populated as tasks in the PDSA task list.	
PREDICTION:	
Outline your prediction of what will happen when you run this test. Your prediction should include what you expect to happen, and why. You may also want to describe the potential consequences of the expected outcome. When writing your prediction, if you identify an adverse outcome that you believe could/should be avoided, try adjusting the plan to reduce the chance of that negative outcome occurring.	
DO: *What happened*	
Describe what happened when you ran your test and note any pertinent observations.	
STUDY: *Compare to your prediction*	
Compare the results from your test to your predictions and summarize any learning.	

ACT: *What next*	
Describe what modifications to the plan will be made for the next cycle.	

DATA COLLECTION				
MEASUREMENT (AIM, Primary, Secondary): **1.**	***Baseline***		***October 2022***	
	August 2022		***November 2022***	
	September 2022		***December 2022***	
	Outcome			
2.	***Baseline***		***October 2022***	
	August 2022		***November 2022***	
	September 2022		***December 2022***	
	Outcome			
3.	***Baseline***		***October 2022***	
	August 2022		***November 2022***	
	September 2022		***December 2022***	
	Outcome			
MEASUREMENT (AIM, Primary, Secondary): **1.** *Increase VL suppression on the Care Continuum Dashboard to 78%.*	***Baseline***		***October 2022***	
	August 2022		***November 2022***	
	September 2022		***December 2022***	
	Outcome			