QI TOOLKIT

A Quality Improvement Resource Guide for Miami-Dade County Ryan White Part A/MAI Providers

CQM Program
Ryan White Part A/MAI
Miami-Dade County

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Quality Improvement Toolkit

- The Quality Improvement Toolkit is a comprehensive resource guide for Miami-Dade County Ryan White Part A/MAI Sub-recipients. The toolkit provides a detailed overview of quality management, HRSA requirements of Clinical Quality Management (CQM), quality improvement (QI) methodologies, and how to complete a quality improvement project from start to finish.

- The toolkit also includes detailed instructions, examples, templates needed to launch and complete a successful quality improvement project, and instructions on managing performance measurement and improvement within each sub-recipient organization.

- In addition, the toolkit provides a basic timeline for when a quality improvement project is meant to be started and completed each year. Sub-recipients should use this as a guide for their quality improvement efforts and are encouraged to request technical assistance from the Quality Management Team at Behavioral Science Research (BSR) as needed.

What is Quality Management?

The Institute of Medicine defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

Quality management under the Ryan White HIV/AIDS Program involves activities to improve client health outcomes by developing and implementing quality management programs. These efforts focus on establishing standards and systems to measure and improve performance. Based on the Policy Clarification Notice (PCN) 15-02, all Ryan White HIV/AIDS Programs (RWHAP) are required to have a clinical quality management (CQM) program to:

- Assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines (otherwise known as the HHS Guidelines) for the treatment of HIV disease and related opportunistic infections; and

- Develop strategies to ensure that such services are consistent with the guidelines for improvement in the access to and quality of HIV services.

Quality Assurance vs. Quality Improvement

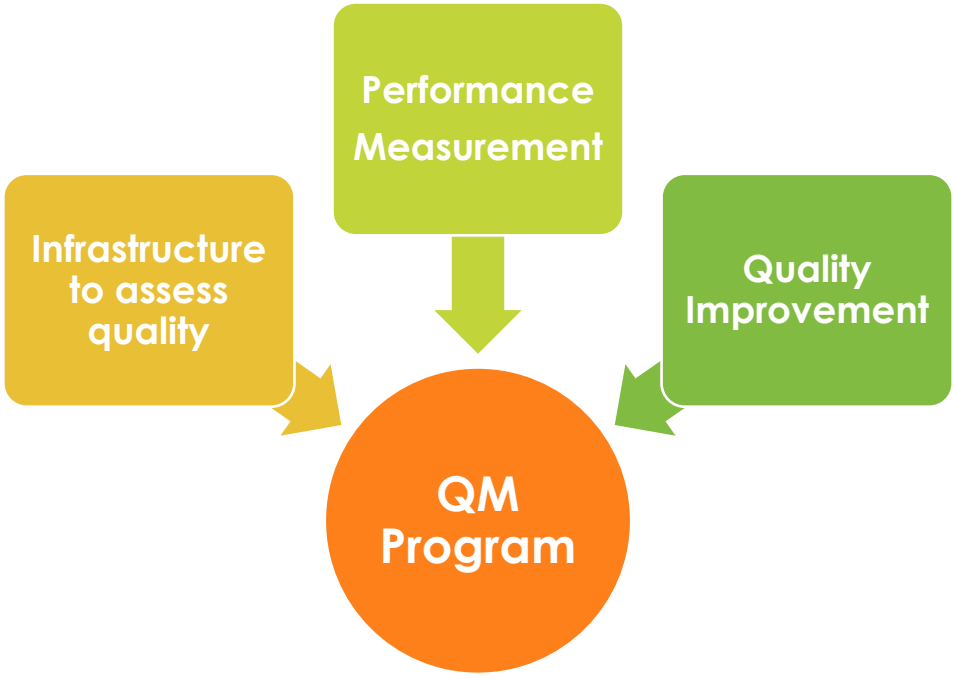
	Quality Assurance	Quality Improvement
Motivation	Measuring compliance with standards	Continuously improving processes and health outcomes
Attitude	Required, reactive	Chosen, proactive

Focus	Outliers: "bad apples," Individuals	Processes, Systems
Responsibility	Designated Staff	All Staff
Examples	Chart review, Peer review, Audits	PDSA Cycles, Pilot Testing

The Quality Management Program is a structured framework that focuses on ensuring quality management plan is conducted ethically, scientifically, and grounded on evidence base/ evidence informed intervention to achieve improvement in client health outcomes. The quality management program should be guided by the Quality Management Plan.

A. Components of a Quality Management Program

Within the Miami-Dade County EMA, all Part A and MAI funded sub-recipients are expected to have a written quality management program structured to include three major components:



1. Quality Management Infrastructure: Describes how the program is structured and staffed to get work done:

- Leadership involvement and who is ultimately responsible for the QI initiatives.
- Dedicated staffing and resources
    - Quality committee/ workgroup structure: Who chairs the HIV quality committee/workgroup? Which staff serves on the quality committee/work group?
    - Quality committee/workgroup meeting frequency: When will the quality committee/workgroup meet to assess progress and plan future activities?

- Stakeholder and consumer involvement: How will the organization engage staff members and consumers in the Quality improvement process? If HIV quality improvement activities are to become incorporated into the structure of an organization, provisions need to be outlined in the quality management plan for actively engaging staff and consumers, consistently communicating information about quality improvement activities and regularly providing opportunities for learning about quality. More specifically, the quality committee and organizational leadership will need to:

    a. **Engage staff and consumers**: Gaining staff and consumer support for quality improvement requires capturing and integrating their voices. The needs and expectations should be understood, and their feedback must be reflected in the quality improvement management plan. To accomplish this, the quality committee should seek staff and consumer input to the extent feasible. Staff meetings and other informal one-on-one discussions are both appropriate methods. A short questionnaire might be developed and circulated.

    b. **Communicate information about quality improvement activities**: Staff and consumers must know about the facility's quality initiatives on an ongoing basis. A quality management plan should document how the organization will share information about its quality activities and disseminate results.

    c. **Provide opportunities for learning about quality**: Because staff members ultimately bring the quality management plan to life, staff will likely require training and education on quality concepts and skills. The quality management plan should describe how the facility intends to provide staff training and learning opportunities. Options include self-study of quality manuals and quality posters or attendance at formal training sessions about quality. These learning interventions can also be shared with consumers. Organizations should also consider inviting consumers, trained in quality, to participate as quality trainers.

- Quality Management Plan: is a document that outlines the processes and activities used to ensure the quality of the improvement activities. It focuses on monitoring protocol execution, maintaining data integrity, and ensuring the safety of human subjects. Essentially, it's a blueprint for maintaining high standards in clinical quality improvement.

a. The basic elements of a QM plan are

- **Quality Goals:** the work plan must contain goals, SMART (specific, measurable, achievable, relevant and time-bound). Quality goals are endpoints or conditions toward which the sub-recipient will direct its efforts and resources during project work. Quality goals help staff focus on improving aspects of care. While an HIV program can measure several key performance indicators, the available resources for quality improvement work might limit the HIV program to conduct at least one to three quality improvement projects per year.

- **Objectives:** should reflect strategies that ensure a comprehensive, coordinated approach to accomplish the goals.
- **Activities:** detail of what specific activities the CQM team will perform to improve patient care, health outcomes, and satisfaction. These activities include data evaluation, quality improvement projects, and sharing best practices.
- **Responsible parties:** Staff who are responsible for CQM duties and resources.
- **Performance measurement**: is the process of collecting, analyzing, and reporting data regarding patient care, health outcomes on an individual or population level, HIV/AIDS Bureau Policy 15-02 4 and patient satisfaction. In order to appropriately assess outcomes, measurement must occur.
- **CQM program evaluation:** A plan that evaluates the effectiveness of the CQM program to ensure that the CQM activities are making changes that positively affect outcomes.
- **CQM Evaluation Plan:** How will the organization evaluate its overall performance as a quality program? Performance measurement provides hard data about improvements to care delivery over time, but it is also essential to assess how efficiently and effectively the program is operating. There are two areas to consider in program evaluation:

    1. Quality improvement projects conducted during the year: The projects should be a "value-driven" investment in the sub-recipient's quality of care and result in improvements that are sustainable over time.
    2. Effectiveness of the quality management plan: The quality plan should provide the vision and organizational process required to evaluate the effectiveness of the entire quality program.

2. Performance measurement: is the process of collecting, analyzing, and reporting data pertaining to client care, health outcomes, and client satisfaction. This is essential to assembling baseline performance data and measuring the effectiveness of improvement efforts over time.

Based on current guidelines, a viral load test should be conducted at entry to care, two to eight weeks following antiretroviral treatment (ART) initiation and every three to six months, thereafter (https://aidsinfo.nih.gov/guidelines/htmltables/1/7267). Per HRSA Policy Clarification Notice (PCN) 15-02, at least two performance measures must be identified for funded services categories where greater than or equal to 50% of the eligible clients receive at least one unit of service. At least one performance measure must be identified for funded service categories where greater than 15% and less than 50% of eligible clients receive at least one unit of service. It is not required to identify a performance measure for funded services categories where less than or equal to 15% of eligible clients receive at least one unit of service.

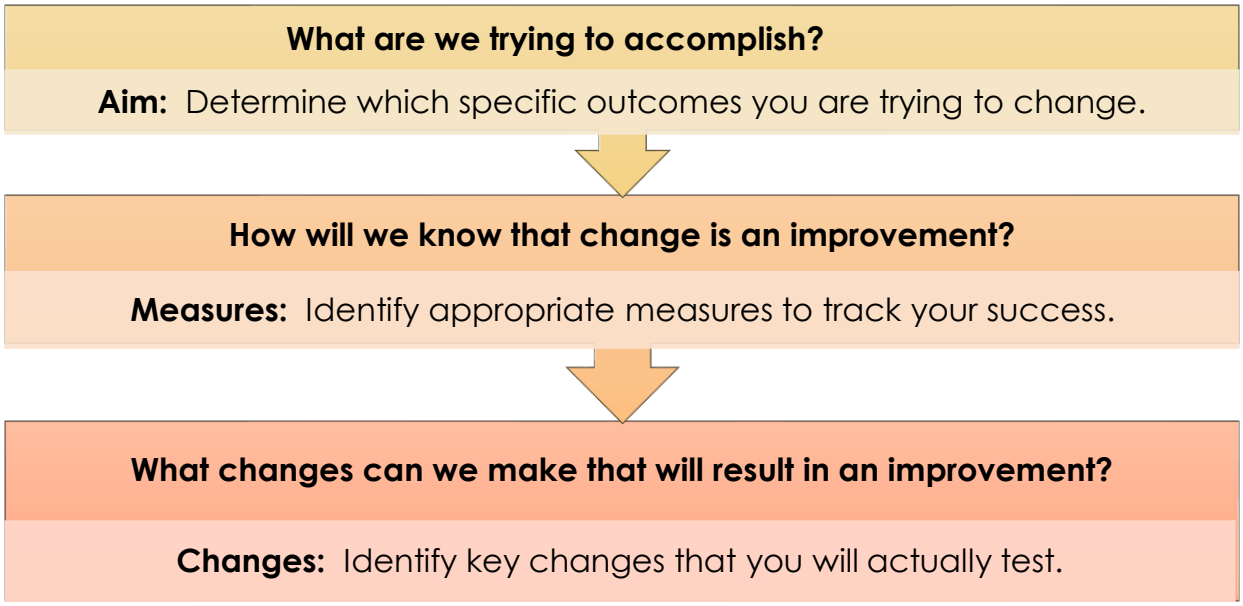
To optimally support quality improvement activities, data collection for the QM performance measures should occur **quarterly, at minimum.**

3. **Quality Improvement:** Quality improvement entails the development and implementation of activities to make changes to the program in response to the performance data results. To do this, the CQM team is required to implement quality improvement activities aimed at improving patient care, health outcomes, and patient satisfaction. The CQM team is expected to implement quality improvement activities using a defined approach or methodology (e.g., model for improvement, Lean). Quality improvement activities should be implemented in an organized, systematic fashion. As a result, the CQM team is able to understand if specific changes or improvements had a positive impact on patient health outcomes or were indicative of further necessary changes in RWHAP funded services. All quality improvement activities should be documented. Subrecipients should conduct quality improvement activities within at least one funded service category at any given time

B. The Model for Improvement (MFI)

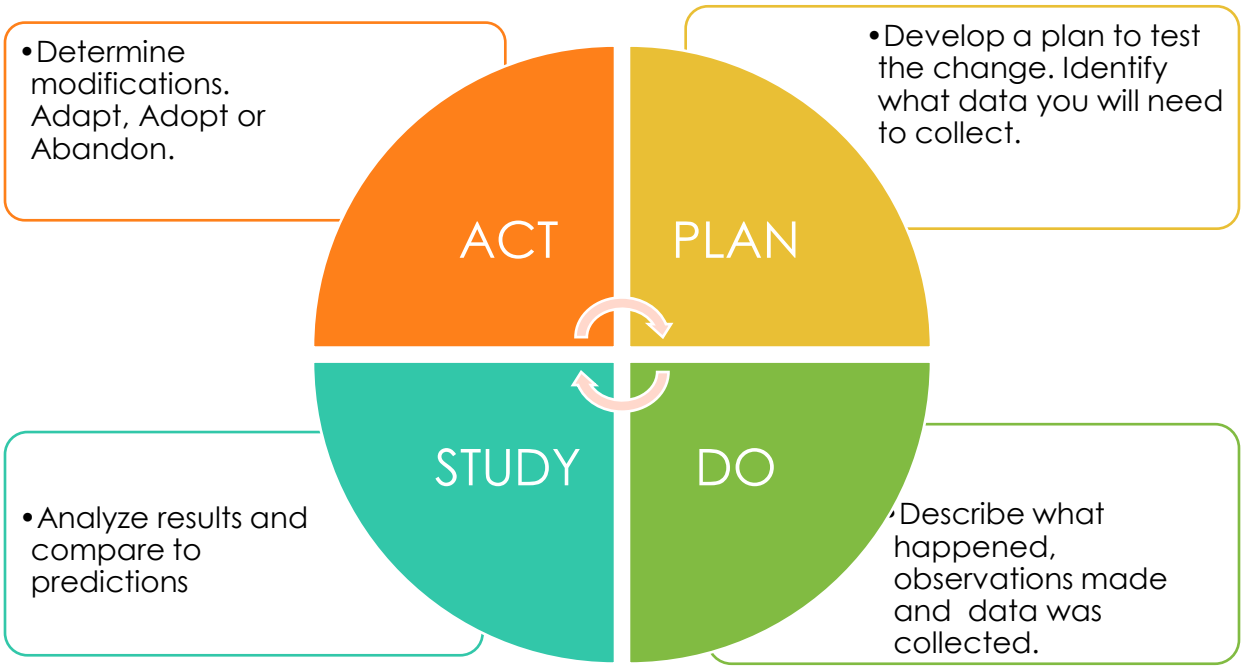
Was developed by Associates in Process Improvement (API) https://www.apiweb.org/, utilized by the Institute for Healthcare Improvement (IHI), and approved by HRSA. The Miami-Dade County EMA utilizes this framework to guide quality improvement.

The MFI has two parts part one consists of the three fundamental questions, which can be addressed in any order, although teams typically start with the first question- What are you trying to accomplish? - to guide them in setting aims.



C. P.D.S.A. Cycle

Part two of the MFI is the Plan-Do-Study-Act (PDSA) cycle, which tests and adapts changes to ensure they result in the desired improvement.



A vital component of this model is creating an aim statement to guide the improvement process.

STEP 1: GETTING READY FOR QIPs

- Examine agency performance measurement data
- Identify areas for improvement

Data-Informed Quality Improvement: Quality improvement should be informed and guided by data.

Data Sources: The Miami-Dade RWHAP program utilizes Provide Enterprise (PE) as the HIV management information system. PE has many features that enable providers to review performance data at the agency level, including the Continuum of Care Report, HAB HIV Performance Measures Report, and Local Outcomes and Indicators. Instructions for utilizing PE to generate reports can be found in Appendix A: PE Reporting Guide.

Dashboard Data: Agency-specific QI Dashboards are disseminated monthly to QI teams at sub-recipient service providers to enable drilling down on client-level data to identify sub-populations of focus that are struggling to meet client health outcome indicators. This allows sub-recipients to identify areas for improvement.

Continuum of Care: The Quality Management Report Card shows the number of clients achieving a specific Continuum of Care step. The steps are calculated as follows:

1. Total Clients: Clients that have received at least one service from the selected service category(s) in the reporting period.
2. In Care: People with HIV who had medical care within the reporting period.
3. Retention in Care: People with HIV who had two or more medical care services* at least 90 days apart in the reporting period.
4. Virally Suppressed: People with HIV who have less than 200 copies/mL in their most recent viral load test result, as of the end of the reporting period.

**Medical Care Service = Medical Visit, Medical visit co-pay, or Viral Load.*

Continuum of Care data can be compared to systemwide Continuum of Care Data, previous year's agency Continuum of Care data, or National HIV/AIDS Strategy (NHAS) goals.

HAB Measures: The HAB Measures Report shows the portion of clients achieving the specified HAB measure in the measurement period. HAB measures are developed by HRSA HAB. The Miami-Dade County EMA utilizes a selection of HAB measures to serve as process and outcome measures. A full listing of HAB measures can be found at https://hab.hrsa.gov/clinical- quality-management/performance-measure-portfolio.

HAB measures data can be compared to EMA-wide HAB measures, previous year's agency data, or internal agency goals.

STEP 2: Identify Focus Areas for Quality Improvement Projects

QIPs aim to improve the quality of care provided to consumers within the EMA

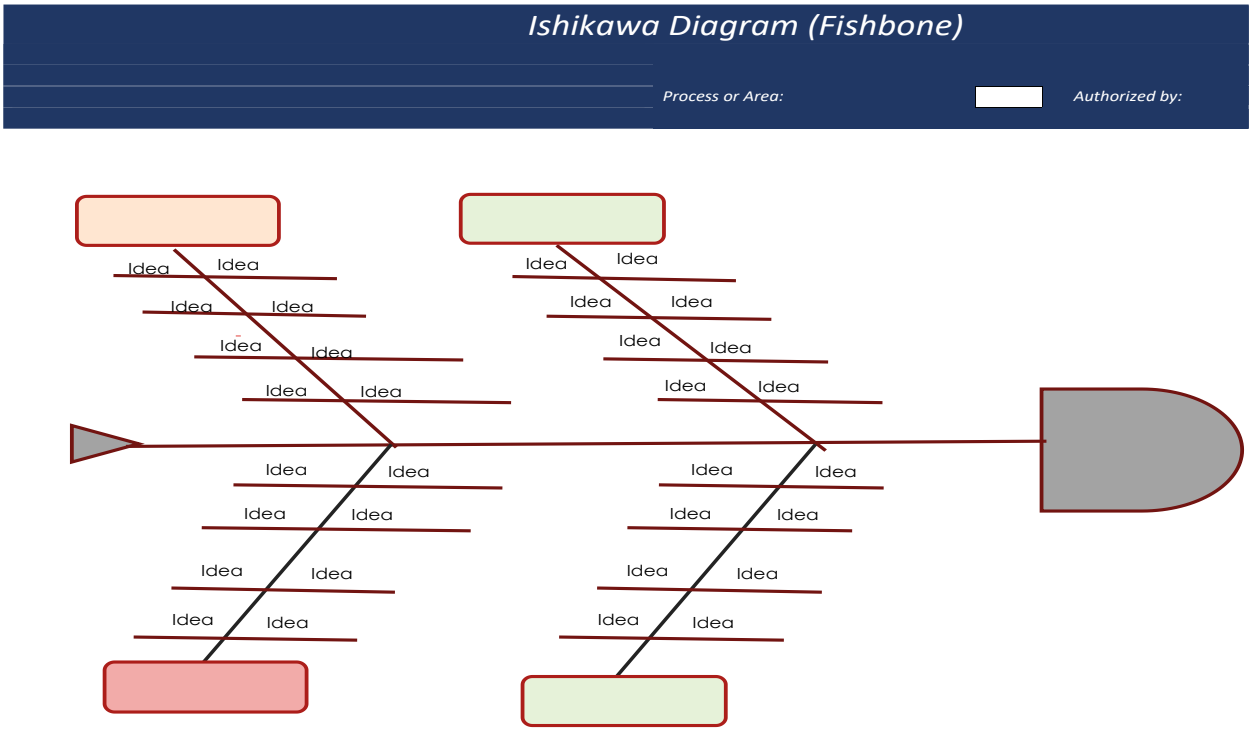
STEP 3: Identifying the Problem; Fishbone/Driver Diagrams

I. Construct a diagram

Fishbone Diagram

A fishbone diagram is a visual way to look at cause and effect. It is a more structured approach than some other tools available for brainstorming causes of a problem (e.g., the Five Whys tool). The problem or effect is displayed at the head or mouth of the fish.

This template illustrates a Cause-and-Effect Diagram, also called a Fishbone or Ishikawa Diagram. A detailed discussion of Cause-and-Effect Diagrams can be found at www.ASQ.org



Instructions

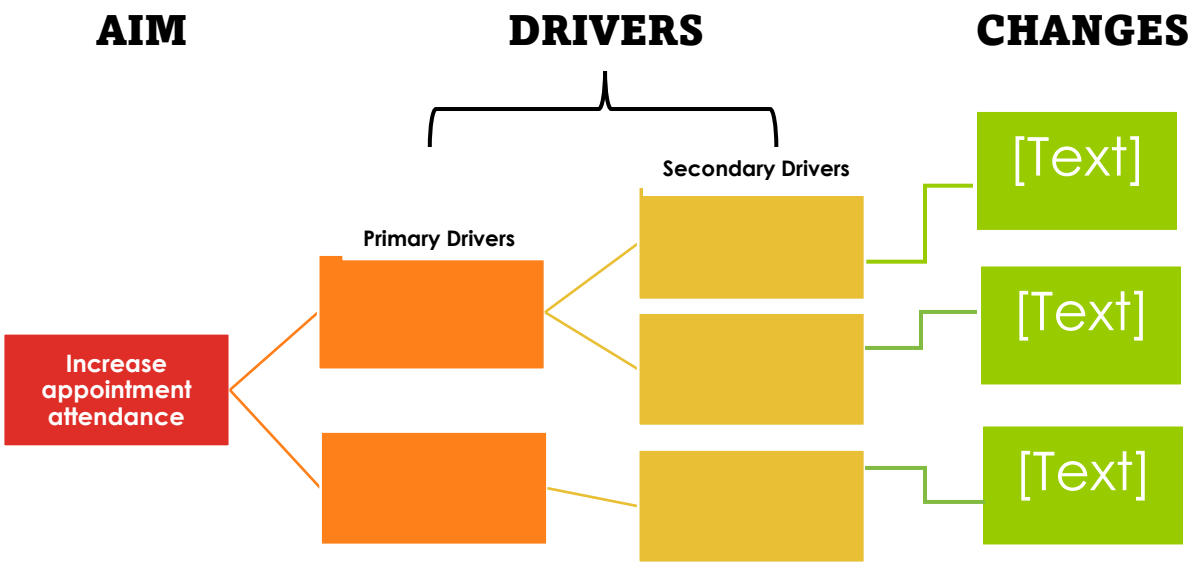
1) Enter the Problem Statement in box provided.
2) Brainstorm the major categories of the problem. Generic headings are provided.
3) Write the categories of causes as branches from the main arrow.

Driver Diagram

A driver diagram is a visual display of a team's theory of what "drives" or contributes to the achievement of a project aim. This clear picture of a team's shared view is a useful tool for communicating with a range of stakeholders where a team is testing and working.

A driver diagram shows the relationship between the overall **aim** of the project, the **primary drivers** (sometimes called "key drivers") that contribute directly to achieving the aim, the **secondary drivers** that are components of the primary drivers, and **specific change ideas to test** for each secondary driver.

Primary drivers are the most important influencers on the aim, and you will have only a few (we recommend 2 to 5). Secondary drivers are influencers on (or natural subsections of) the primary drivers, and you may have many. As you identify each driver, establish a way to measure it. ***Remember:*** **It is unlikely that a single individual has a clear view of an entire complex system. When developing a driver diagram, enlist the help of team members who are familiar with different aspects of the system under review**



Instructions

1) On the left, list the project aim (keep it general for this activity, such as "increase appointment attendance") and draw a box around it.
2) To the right of the aim, list a few "primary drivers" — the most significant high-level influencers on the aim you have identified. Draw a box around each of the primary drivers and draw lines to connect the primary drivers to the aim.
3) To the right of each primary driver, list as many "secondary drivers" as you can think of that influence the primary driver. Draw a box around each secondary driver and draw

lines to connect the secondary drivers to the primary drivers. Note: Secondary drivers can connect to more than one primary driver.

*Tip: To show strong relationships, use solid lines, to show weaker relationships, use dotted lines.

4) To the right of each secondary driver, list specific change ideas you will test to influence the secondary driver. Note: Change ideas can connect to more than one secondary driver.
5) Use different colored highlighters to identify modifiable and non-modifiable primary and secondary drivers.

Five Whys Tool Template

The "five whys" root cause analysis technique is a problem-solving method where you repeatedly ask "why" to uncover the underlying causes of a problem. By iteratively asking "why" five times, you aim to peel away the surface symptoms and get to the fundamental root cause.

Five Whys Tool Template

Problem Statement	One sentence description of the event or problem
Why?	
Why?	
Why?	
Why?	
Why?	
Root Cause(s)	1. To validate root cause, ask the following: If you removed this root cause, would this event or problem have been prevented?

Instructions

1) Define the problem: Clearly identify the issue you're trying to solve.
2) Ask "why": Begin by asking "why" did this problem occur.
3) Iterate and refine: For each answer you get, ask "why" again, building on the previous answers. This process continues until you've asked "why" five times.

4) Identify the root cause: The answer to the fifth "why" (or sometimes sooner) should reveal the fundamental cause of the problem.
5) Develop solutions: Once you've identified the root cause, you can develop and implement solutions to address it.
6) Monitor and evaluate: Regularly monitor the results of your solutions to ensure they are effective and make adjustments as needed

I. Identify modifiable and non-modifiable factors

Modifiable vs. Non-Modifiable Factors

Quality improvement and PDSA cycles involve making a change to improve the quality of care; however, due to various constraints, not all changes are possible. We can consider the things we want to change as modifiable or non-modifiable factors.

A modifiable factor is something possible to change. Examples of modifiable factors could include:

- HIPAA disclosure signs in the waiting area
- How staff greet clients
- Intake forms to using inclusive language for transgender individuals

Some factors are modifiable but would be difficult to change due to organizational, financial, or other constraints. For example, a clinic may wish to have a separate waiting room for adolescent clients; however, this is not feasible due to space constraints.

A non-modifiable factor is something that is not possible to change. Many non-modifiable factors are at the client level. Examples of a non-modifiable factor include:

- Client gender, race, ethnicity, socioeconomic status
- Where a client lives
- Procedures and processes that are mandated by funders, local, state, or federal authorities

It is useful to consider modifiable and non-modifiable factors when developing a driver diagram.

Step 3: Aim Statements; Strategies and Quality Indicators

Tips for Setting Aims

a) Clearly define your aim. This is not always as easy as it sounds. Just improving is not a clear enough objective to engage and motivate your team to improve. Having a “How much” and “by when” aim may seem ambitious; however, it is much better to not quite fulfill your aim than to not have any significant measurable improvement because of an ambiguous aim.

b) Include numerical goals that require a fundamental change to the system. Teams are more successful when they have clear, focused aims. Setting numerical goals clarifies the aim, helps to create tension for change, directs measurement, and focuses on initial changes.

For example, the aim "Reduce waiting room time" is not as effective as "Reduce patient appointment wait time for a provider by 50% within 12 months." Including numerical goals not only clarifies the aim but also helps team members begin to think about what their measures of improvement will be, what initial changes they might make, and what level of support they will need.

c) Set stretch goals. A "stretch" goal is one to reach within a specific time. Setting stretch goals such as "Reduce patient appointment wait time for a provider by 50% within 12 months" communicates immediately and clearly that maintaining the status quo is not an option. Effective leaders make it clear that the goal cannot be met by tweaking the existing system. Once this is clear, people begin to look for ways to overcome barriers and achieve goals

d) Avoid aim drift. Once the aim has been set, the team needs to be careful not to back away from it deliberately or "drift" away from it unconsciously. The initial stretch goal, "Reduce patient appointment wait time for a provider by 50% within 12 months," can slip almost imperceptibly to "Reduce patient appointment wait time for a provider by 40%" or "by 20%." To avoid drifting away from the aim, repeat the aim continually. Start each team meeting with an explicit statement of aim, for example, "Remember, we're here to reduce patient appointment time for a provider by 50% within 12 months," and then review progress quantitatively over time.

e) Be prepared to refocus the aim. Every team needs to recognize when to refocus its aim. If the team's overall aim is at a system level (for example, "Increase domestic violence screening by 30% within 12 months"), team members may find that focusing for a time on a smaller part of the system (for example, "Increase domestic violence screening for patients new to care by 30% within 12 months") will help them achieve the desired system-level goal. Note: Do not confuse aim drift or backing away from a stretch goal (which usually is not a good tactic), with consciously deciding to work on a smaller part of the system (which often is a good tactic).

Step 4: Measurement and PDSA Cycles

I. Quality Measurement

A quality measure is a tool to assess specific aspects of care and services that are linked to better health outcomes while being consistent with current professional knowledge and meeting client needs.

Process Measures evaluate the actions taken to produce the outcome and the procedures for achieving the best outcomes.

Outcome Measures measure the result. Outcome indicators are used to evaluate if you met your goal.

Balancing Measures are used by improvement teams to see whether the improvement work is having an unintended consequence in the system.

What makes a good measure?

- Relevance
  - Does the indicator affect many clients?
  - Does the indicator have a significant impact on the programs or clients?
- Measurability
  - Can the indicator realistically and efficiently be measured given finite resources?
- Accuracy
  - Is the indicator based on acceptable guidelines or developed through formal group-decision making methods?
- Improvability
  - Can the performance rate associated with the indicator realistically be improved given the limitations of your services and populations?

II. PDSA Cycle

PDSA Cycle is a rapid test of improvement. When a change idea is generated, the PDSA cycle allows for a structured approach to rapid testing of the idea of a small scale. Commonly stated, a journey of a mile begins with little steps. The PDSA cycle is continuous, and the trend should be an uphill one if the approach is correct.

Plan: Clarify your Objective; Make a prediction; What is to be done (Who, What, Where When, How)

Do: Carry out the plan; Document your observations (Expected/Unexpected); Begin analysis.

Study: Look at the test; Complete the analysis of data; Compare it to your theory and predictions; Summarize what you have learned.

Act: Adjustments; Changes to previous test? What adjustments? Expand last cycle? New Cycles: What are you planning? What are you going to test?

Ramping Up Your PDSA Cycles:

A PDSA ramp is a set of related, repeated cycles focused on the change idea. A more detailed breakdown of the second iteration is:

Study: Analyze the data collected during the "Do" phase for the first cycle to identify what worked well, what didn't, and what adjustments are needed.

Act: Based on the "Study" findings, make necessary changes to your plan, actions or resources.

Plan: Develop a revised plan that incorporates the lessons learned from the first cycle.

Do: Execute the refined plan and collect data to assess the impact of the changes.

Repeat: Continue cycling through the PDSA cycle, iterating and refining your approach based on each cycle's findings.

Tips for Effective PDSA Cycles

a) In the Beginning, Test on a Small Scale

b) Keep the first test small. A common question to those starting their first PDSA Cycle is: what change can you implement by next Tuesday? This question forces you to think small by reducing the sample size, such as “just a few records.” Then, decreasing the implementation timetable, “within a few days,” to a minimum.

c) One way to help you and your colleagues “keep it small” is to remember the Rule of 1. Design the first test for one facility, one office, one provider, or one patient. See what happens, act on that knowledge, and then scale-up the test.

CQM Program
Ryan White Part A/MAI
Miami-Dade County

QI Project

Insert (Name of Project)

Model for Improvement & PDSA Stages

THREE QUESTIONS FOR IMPROVEMENT

1. WHAT ARE YOU TRYING TO ACCOMPLISH (STATE YOUR AIM)

Aim Statement:
Specific- targeted population:
Measurable- what to measure and clearly stated goal:
Achievable- brief plan to accomplish it:
Time Specific- anticipated length of cycle:

2. HOW WILL YOU KNOW THAT A CHANGE IS AN IMPROVEMENT? (DESCRIBE THE MEASURABLE OUTCOME(S) YOU WANT TO SEE)

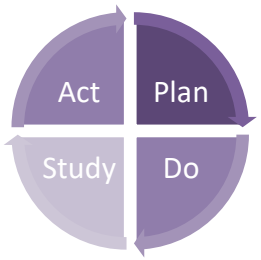
3. WHAT CHANGES CAN WE MAKE THAT WILL RESULT IN AN IMPROVEMENT? (DEFINE THE PROCESS CURRENTLY IN PLACE (USE PROCESS MAPPING OR FLOW CHARTING)

Identify opportunities for improvement that exist (look for causes of problems that have occurred – see Guidance for Performing Root Cause Analysis with Performance Improvement Projects

Decide what you will change in the process; determine your intervention based on your analysis

- Identify better ways to do things that address the root causes of the problem
- Learn what has worked at other organizations (copy)
- Review the best available evidence for what works (literature, studies, experts, guidelines)
- Remember that solution doesn't have to be perfect the first time

PDSA Cycle Template



Plan • What is the objective of the test? • What do you predict will happen and why? • What change will you make? • Who will it involve (e.g. one unit, one floor, one department)? • How long will the change take to implement? • What resources will they need? • What data need to be collected?	List your action steps along with person(s) responsible
Do • Implement the change. Try out the test on a small scale. • Carry out the test. • Document problems and unexpected observations. • Begin analysis of the data.	**Describe what actually happened when you ran the test**
Study Set aside time to analyze the data and study the results and determine if the change resulted in the expected outcome. • Complete the analysis of the data. • Compare the data to your predictions. • Summarize and reflect on what was learned. Look for: unintended consequences, surprises, successes, failures.	**Describe the measured results and how they compared to the predictions**
Act If the results were not what you wanted you try something else Refine the change, based on what was learned from the test. • Adapt – modify the changes and repeat PDSA cycle • Adopt – consider expanding the changes in your organization to additional residents, staff, units • Abandon – change your approach and repeat PDSA cycle	**Describe what modifications to the plan will be made for the next cycle from what you learned** #