Bergen-Passaic TRANSITIONAL GRANT AREA

Ryan White HIV/AIDS Program – Part A

Clinical Quality Management Plan
Grant Year 2023-1 UPDATE

Approved March 14, 2023

COLLABORATIVE RESEARCH

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Introduction

The Bergen-Passaic Transitional Grant Area (TGA) consist of two counties (Bergen and Passaic Counties) in northeast New Jersey. The TGA is geographically the second smallest of the nine New Jersey planning regions, the second largest in general population and is the second most densely populated. The CEO for the Ryan White HIV/AIDS Program (RWHAP) Part A funds is Mayor of the City of Paterson, New Jersey. 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 Part A subrecipients to continuously improve the quality of care, service delivery, and health outcomes for people with HIV (PWH) in the Bergen-Passaic TGA, with a vision of *Ending the Epidemic.*

Quality Statement

The Clinical Quality Management Program (CQMP) of the Bergen-Passaic TGA is a coordinated, comprehensive, and continuous effort to monitor and improve the quality of care provided to PWH throughout the Bergen-Passaic TGA. The RWHAP, Part A Program Director, 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 Bergen-Passaic TGA CQMP. These components will ensure that service delivery is effective and equitable for RWHAP eligible PWH in the Bergen-Passaic TGA:

- **Infrastructure**: the backbone of a CQM program, detailing the roles of the CQMC, RWPA staff, RWHAP subrecipients, RWPA 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, RWHAP staff, RWHAP subrecipients, RWPA 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 Program Director.

- **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 CQM Program operates through the Clinical Quality Management Committee (CQMC) which receives guidance and support from the RWPA Recipients Office. Participation of subrecipient's receiving funding from the RWPA program is required. Input is received from all RWPA 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 Bergen-Passaic 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 Milagros Izquierdo	Ryan White Program Director HOPWA Program Director Committee Member	• 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 • 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

Collaborative Research Thomas Rodriguez-Schucker Deryk Jackson Clifford Barnett Andy McCracken	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
RDE Systems Robert Folgar	eCOMPAS Consultant Committee Member	• Attends all CQM committee meetings • Provides statistical reports that consist of tracking clinical outcomes in eCOMPAS 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 eCOMPAS • Imports current VL, CD4s, and other care labs from both local and state health departments to ensure accurate reporting as needed for QI
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 **Bergen Family Center** Paula Tenebruso **Buddies of New Jersey** Abraham Corsino **CAPCO** Tisa Smith **Passaic Alliance** Grace Jones	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 • Involved in day-to-day activities related to quality improvement projects and PDSA's in a proactive manner

Hackensack University & Medical Center Donna Wilson **Hyacinth AIDS Foundation** Jokebed Saintil **Northeast New Jersey Legal Svc** Mallory Ware **Paterson Counseling** Alicia Blakney **Paterson Dept of Health** Vacant **Preparing Adolescents & Adults Ideology Now (PAAIN)** Roger Lester **St. Joseph's Hospital** Vacant **St Mary's General Hospital** Priscilla Moschella **Straight and Narrow** Gloria Price **Team Management 2000** Vacant		• 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 State of New Jersey Vacant	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 St. Joseph's Hospital Vacant	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
HOPWA Recipient Denise Coba	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 Planning & Development Committee	• 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 • P&D Committee meets monthly • 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) Michelle Thompson **War Talley**	• 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 Recipient and CQM Consultant will evaluate and update the CQM plan annually with the guidance and support from the Bergen-Passaic 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 make adjustments 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 *March 2023* *September 2023* *March 2024*	• CQM Committee presentation • P&D 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 • P&D Committee presentation • Planning Council presentation • TGA website publication
Service-specific Outcome Reports Care Continuum Dashboards	Recipient RW Part B RW Part C HOPWA CQM Committee Planning Council Community Stake Holders	Biannual Report April 2023 October 2023 April 2024	• CQM Committee presentation • TGA website publication • Basecamp publication
Annual Quality Assurance Outcomes	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	• TGA website publication • Basecamp publication

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 Bergen-Passaic 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 Bergen-Passaic TGA is currently monitoring the following service categories: Health Education/Risk Reduction (HERR), Medical Case Management (MCM), Outpatient Ambulatory Health Services (OAHS), Non-Medical Case Management (NMCM) and Outreach Services. 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

Bergen-Passaic TGA Performance Measure Portfolio GY2023

*GY2022/23 Service Utilization Data

Service Category	Total Eligible Clients	Denominator	Numerator	Performance Score	Number of Measures
Early Intervention Services	1975	1975	52	2.63%	0
Food Bank/Home Delivered Meals	1975	1975	151	7.65%	0
Health Education / Risk Reduction Services	1975	1975	255	12.91%	0
Health Insurance Premium and Cost Sharing Assistance	1975	1975	1	0.05%	0
Medical Case Management	1975	1975	323	16.35%	1
Medical Transportation Services	1975	1975	157	7.95%	0
Mental Health Services	1975	1975	118	5.97%	0
Non-Medical Case Management	1975	1975	785	39.75%	1
Oral Health Services	1975	1975	167	8.46%	0
Other: Legal Services	1975	1975	24	1.22%	0
Outpatient Ambulatory Health Services	1975	1975	354	17.92%	1
Outreach Services	1975	1975	1272	64.41%	2
Psychosocial Support Services	1975	1975	39	1.97%	0
Substance Use Treatment - Outpatient	1975	1975	200	10.13%	0

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

- HIV-Diagnosed – Numerator: Total HIV primary medical patients who are enrolled in RW active or inactive in the measurement year. Denominator: Total HIV primary medical patients who are enrolled in RW active or inactive in the measurement year.

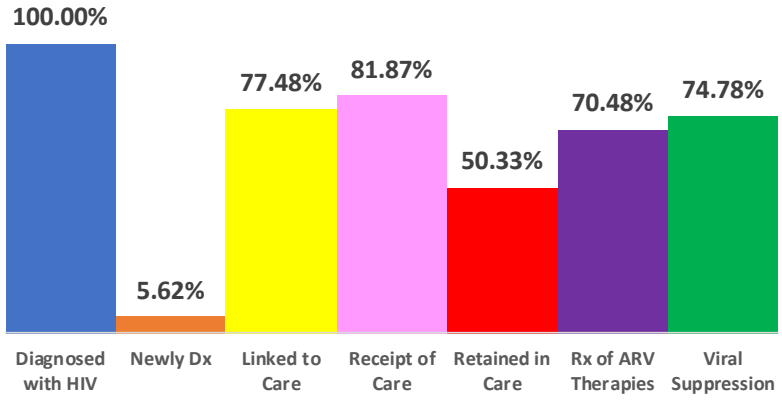
- Linkage to Care – Numerator: Number of primary medical patients in the denominator who have at least one CD4, VL test or medical visit in 12 months and still alive within the measurement period. Exclude patients who died at any time during the 24-month measurement period. Denominator: Total HIV primary medical patients who are enrolled in RW active or inactive in the measurement year.
- Retained in Care – Numerator: Number of live patients who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period. Exclude patients who died at any time during the 24-month measurement period. Denominator: Total HIV primary medical patients who are actively enrolled in the measurement year.
- On Antiretroviral Therapy – Numerator: Number of patients from the numerator Linked to Care prescribed HIV antiretroviral therapy during the measurement period. Exclude patients who died at any time during the 24-month measurement period. Denominator: Total HIV primary medical patients who are enrolled in RW active or inactive in the measurement year
- Virally Suppressed – Numerator: Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement period. Exclude patients who died at any time during the 24-month measurement period. Denominator: Total HIV primary medical patients who are enrolled in RW active or inactive in the measurement period.

Bergen-Passaic TGA

Care Continuum Dashboard GY2022

***GY2022/23 (March 1, 2022 to February 28, 2023)**

	Total	%
Diagnosed with HIV	1975	100.00%
Newly Dx	111	5.62%
Linked to Care	86	77.48%
Receipt of Care	1617	81.87%
Retained in Care	994	50.33%
Rx of ARV Therapies	1392	70.48%
Viral Suppression	1477	74.78%



Quality Improvement

The Ryan White Recipient and CQM Consultant works with subrecipients to build capacity and provide guidance on prioritizing measures and data collection to identify improvement opportunities and monitor QI activities.

The Bergen-Passaic 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 Bergen-Passaic 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 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: 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.

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 seven (7) 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. Next, the **Completed** section will be utilized to indicate the outcome of the goal or 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: • GY23 Update Plan PENDING 3/14/2023 – To be Reviewed • GY23 Update FUTURE September 2023 – To be updated • GY24 Update – FUTURE March 2024– To be updated	1. The Recipient and CQM Consultant present the CQM Committee with the updated GY23 plan for review. 2. The CQM Committee will review the plan and make proposed changes at the March 2023 meeting. 3. The CQM Committee will present to the Recipient a finalized plan by the end of the March 2023 meeting. 4. The Recipient will review and endorse the final plan.	March 2023 September 2023 March 2024	Recipient CQM Consultant CQM Committee	Presented to the CQM Committee on February 14, 2023 for review Updated and Approved by CQM Committee on March 14, 2023
Subrecipient SPOC to submit Quality Improvement Worksheets to Recipients and CQM consultant for review and approval.	In Planning: • GY23-1 QIP Worksheets due by April 2023 CQM Meeting • GY23-2 QIP Worksheets due by October 2023 CQM Meetings.	1. Quality Improvement Worksheet to be completed by Subrecipient by the April 2023 and October 2023 Committee meetings.	4/2023 10/2023	Recipient CQM Consultant SPOCs CQM Committee	GY23-1 QIP cycle to begin April 2023. GY23-2 QIP cycle to begin October 2023.
Conduct reviews of Subrecipient quality improvement initiatives/PDSAs.	Future: • Recipient and CQM Consultant to complete review proposed QIP by May & November 2023.	1. Recipient and CQM Consultant to review Quality Improvement Worksheets by the May and November 2023 meetings. 2. SPOCs to present QI Projects/PDSAs at the April & October 2023 CQM Committee meeting	4/2023 10/2023	Recipient CQM Consultant SPOCs CQM Committee	GY23-1 QIP Presented in September 2023 GY23-2 QIP Presented in February 2024
		1.			
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 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.	September 2023 February 2024	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: • GY23-1 QIP Worksheets due by September 2023CQM Meeting • GY23-2 QIP Worksheets due by February 2024 CQM meeting	1. GY23-1 QIP Worksheets due by September 2023 CQM Meeting 2. GY23-2 QIP Worksheets due by February 2024 CQM meeting	September 2023 February 2024	Recipient CQM Consultant SPOCs CQM Committee	All QI/PDSA cycle to begin in April 2024.
Conduct reviews of Subrecipient quality improvement initiatives/PDSAs.	Future: • Recipient and CQM Consultant review GY23-1 QIP by May 2023. • Recipient and CQM Consultant review GY23-1 QIP by November 2023.	• 1. Recipient and CQM Consultant review GY23-1 QIP by May 2023. 2. Recipient and CQM Consultant review GY23-1 QIP by November 2023. 3. SPOCs to present QI Projects/PDSAs at the April and September 2023 CQM Committee meeting	April 2023 September 2023	Recipient CQM Consultant SPOCs CQM Committee	GY23-1 QIP cycle to begin April 2023. GY23-2 QIP cycle to begin October 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 in GY2023/24	1. SPOC to present CoC Dashboard at each meeting.	March 2023 April 2023 May 2023 June 2023 July 2023 August 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 September 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.	September 2023	CQM Leadership QM Contractor QM Committee	Provide TA to SPOC on QI/PDSA outcomes as needed.

Capacity Building

The Recipient 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 subrecpients 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.

Signature: Milagros Izquerdo
Milagros Izquerdo (Mar 24, 2023 17:23 EDT)

Email: mizquierdo@patersonnj.gov

Mar 24, 2023

Approved by Milagros Izquierdo, Recipient — Date

Appendix A: Quality Improvement Project Worksheet

Milagros Izquierdo
Division Director

City of Paterson, New Jersey
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			
AIM: *(From Above)*	**PRIMARY DRIVERS:** **1.**	**SECONDARY DRIVERS:**	**CHANGE IDEAS** •
	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***	***63%***	***October 2022***	***67%***
	August 2022	***66%***	***November 2022***	***69%***
	September 2022	***62%***	***December 2022***	***71%***
	Outcome		***63% to 71%***	