# STATE-WIDE QUALITY IMPROVEMENT PLAN

## APPROVED BY STATEWIDE QUALITY TEAM MARCH 2009

## COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

## HIV CARE AND TREATMENT PROGRAM

## I. Purpose:

The purpose of this plan is to set forth a coordinated approach to addressing quality assessment and process improvement for Ryan White Part B entities throughout Colorado. The program has established as its vision: The Colorado Department of Public Health and Environment HIV Care and Treatment Program is committed to continually improving access to medical care, retention and adherence to medical care and access to support services that meet the identified needs of people living with HIV/AIDS who reside in Colorado.

## II. Goals and Objectives:

The HIV/STI Care and Treatment Program recognizes that care for those living with HIV/AIDS is complex and requires contributions from a continuum of care service providers, bridging all parts of the Ryan White Care Act. The intent of this plan is to:

- leverage the contributions of Part B funded programs to improve overall care as measured by system wide metrics;
- improve service delivery and efficiencies within Part B funded agencies as demonstrated by organizational metrics;
- build capacity of Part B programs to measure and improve quality.

The QI Plan will be a systematic, state-wide process for planning, designing, measuring, assessing and improving performance utilizing the following guiding principles:

A. ***The QI Plan development and annual evaluation process will engage key stakeholders.*** The Quality Improvement Plan is intended to address relevant issues as identified from a variety of sources including but not limited to: consumers, Part B funded agencies, issues identified during the preparation of the coordinated statement of need and other internal and external evaluations. Clinical, operational and programmatic aspects of patient care will be reviewed to evaluate for opportunities for improvement. Annual evaluation of the plan will be

incorporated into the work of the Quality Improvement Committee to assure that the plan continues to be relevant to the current status of the epidemic within Colorado.

B. ***The core quality improvement work will occur at the local organization level and will include quality improvement projects to improve both processes and outcomes of care.*** These might include processes associated with new and existing services, patient care delivery, work flows, care coordination with other agencies and support systems which maximize results and satisfaction on the part of the patients and their families, physicians and staff. Quality improvement is ultimately targeted toward improved outcomes for patients as measured by effective prevention strategies, decreased disease burden, effective evidence-based care and optimized quality of life.

C. ***Standardized measurement strategies will be utilized.*** Measurement systems will be deployed at a system level to evaluate health care outcomes for the state population of PLWHA. Measurement will also be utilized for Part B funded entities to assess the effects of changes as well as to evaluate for best practices. Measurement and data collection will be accomplished by collecting and utilizing available data in a disciplined and standardized manner, employing appropriate sampling methodology as appropriate.

D. ***Care Standards may be used as appropriate*** to provide objective assessments of service provision and to identify opportunities for improvement.

E. ***Multidisciplinary team approaches*** to problem solving are encouraged at all levels of the Quality Improvement infrastructure. Teams should use available data to improve quality in all dimensions.

***F. Communication, transparency and sharing of lessons learned will be encouraged*** across the Part B funded agencies and throughout the supporting quality infrastructure ***,*** with regard to findings, analyses, conclusions, recommendations, actions and evaluations pertaining to performance ***.***

***G. The value of collaboration of diverse community agencies is recognized as integral to the success of the provision of a high-quality continuum of care for PLWHA.***

## III. Structure

### A. Framework

**<u>Leadership</u>**

HIV Care & Treatment is one program within the HIV/STI Section residing under the Division of Disease Control and Environmental Epidemiology within the Colorado Department of Public Health and Environment. The HIV Care & Treatment Program Manager oversees the Ryan White Part B grant and is responsible for the Quality Improvement (QI) Program. In addition to the Program Manager, the QI Advance Team within HIV Care & Treatment includes the following staff:

- CDPHE Staff: Coordinator of AIDS Drugs Assistance Program

- CDPHE Staff: Coordinator of Contracting
- CDPHE Staff: Coordinator of Bridging the Gap (Medicare D gap assistance program), Insurance Subsidy Programs,
- CDPHE Staff: Project Assistant, Data entry/management support
- Elected Co-chair of the Quality Committee
- Quality Improvement Consultants

This team is responsible for creating and implementing the QI Plan, gathering and reporting the data from the various databases, evaluating program elements and reporting on the findings, supporting the development, prioritization and implementation of the PDSA (Plan/Do/Study/Act)/improvement change activities and providing input and feedback to the overall QI Program. The QI Advance Team will utilize the Quality Improvement Work Plan, found in appendix A, to document accountability for each aspect of the program and track and monitor the activities of the QI Program.

**Quality Improvement Committee**

The Quality Improvement Committee (QI Committee) was formed to centralize and coordinate quality improvement efforts across Ryan White contractors statewide. The QI Committee is responsible for reviewing the QI Plan, establishing shared quality measures, promoting collaboration among contractors, ensuring consumer involvement and means to influence the QI Plan, and supporting the development and implementation of the PDSA/improvement change activities. Sub committees may be created as needed.

Membership on the Committee is voluntary. Persons interested in volunteering will submit requests to the HIV Care and Treatment Manager or to the QI Committee. The QI Committee membership will be reviewed annually, and may be composed of the following stakeholders:

- Representatives from Ryan White Program Parts A, B, C, D, and F
- Representative of the ADAP Program
- CDPHE staff person from the HIV/STI surveillance team
- Quality liaisons from the statewide contractors receiving Part B funds

- Consumers representing both urban and rural areas
- QI Contractors

There will be two co-chairs. One will be elected by the Quality Improvement Committee, the other will be a member of the Advance Quality Team.

**Communication**

The QI Committee will meet quarterly. Conference calls and electronic communication will be on-going.

The Manager of the HIV Care and Treatment Program reports quality activities to the HIV/STI Section Chief. The Manager and the QI Committee also report QI activities through the HIV Care Advisory Committee of the Colorado HIV/AIDS Care and Prevention Coalition and may utilize the Colorado HIV/AIDS Planning Collaborative Committee to promote information sharing, collaboration and standardization between Parts A and B.

**B. Content**

The QI program is designed to address quality assessment and improvement among the following key focus areas:

- Access to Care
- Retention in Care
- Adherence to Treatment
- Evidence-based care

The QI Program will take a multi-disciplinary approach to affect change within the four key focus areas by targeting efforts across the funded service categories, particularly HIV Medical care, Medical Case Management, ADAP and Insurance Programs, and other support services. These efforts will include:

- Monitoring System Level Measures
- Monitoring both process and outcome measures on the provider/service level
- Utilizing the Model for Improvement (including PDSA cycles)
- Providing capacity building through QI Training opportunities
- Providing individualized technical assistance for each funded organization/program:

a. To develop its own QI Program including a QI Plan and Model for Improvement testing cycles.
b. To improve its ability to manage and report on required quality measures

In addition, the leaders of the QI Infrastructure will continue to coordinate efforts with other Ryan White grantees and other organizations involved in supporting the continuum of care for PLWHA. These efforts could involve standardization of supporting data collection strategies, alignment of goals and measures or strategies to fill identified gaps in care.

**C. Data Collection Plan**

- Performance measures for the major functional areas and the important aspects of care and service are selected and reviewed annually. Selected performance measures, specific data collection strategies and periodicity of review can be found in Appendix A: Quality Improvement Work Plan.

- Regular review of data for performance measures from a variety of sources will occur as per the schedule attached as Appendix A. The QI Committee Chairperson will coordinate these activities. Data reports will be presented for review to Quality Committee and designated teams. Data sources will include but will not be limited to:

    - Data collected by each organization to monitor selected performance measures.
    - Data collected by the state to monitor selected system level measures.
    - Patient Satisfaction Survey results administered at local organizations as well as by CDPHE.
    - Demographic data, visit frequency and missed appointment data from CAREWare, HELIX, ADAP databases or other electronic data systems.
    - Data as available from consumers or consumer advisory boards
    - Data from other Ryan White funded entities as it contributes to monitoring quality improvement activities.
    - Observations by State staff made during site visits.

- Data collection will be implemented utilizing appropriate sampling methodology and will include both concurrent and retrospective review.

**D. Assessment and Evaluation**

Assessment and evaluation of the data will be performed following the attached recommended schedule (Appendix A). Individual performance measures will be assessed by the QI Committee to

determine if current efforts are generating the desired improvement or if additional evaluation is warranted. Where benchmarks and standards of care exist, efforts to achieve those standards at minimum should be accelerated. Organizations Quality Improvement Teams will be supported by training and technical assistance as needed to attain desired improvements. Evaluation of the QI Plan will be accomplished by the QI Committee on an annual basis.

## E. State-wide Multidisciplinary Quality Improvement Teams and Development of Improvement Projects

The QI Advance Team and the QI Committee will utilize data to select and prioritize areas in which to focus statewide or system Improvement projects.

Once an opportunity for improvement has been identified the core quality improvement work will occur within organization designed quality improvement projects. QI Teams at each organization will develop improvement projects appropriate for their setting. Every attempt will be made to include individuals from other organizations who may be impacted by changes made by the team and to help promote collaboration between providers and across Ryan White Parts.

The QI Team will seek to identify projects that are:

- Focused: Defined parameters, not cumbersome to implement or analyze data
- Supportable: Staff and providers who will need to implement the change agree that they can "live with" the change
- Immediate: Pilot tests should be able to show visible change in the short term
- Measurable: Can the project's effectiveness be measured over time?

Continuous Quality Improvement Methodology will be utilized and will include but not be limited to the following:

- Model for Improvement and PDSA (Plan/Do/Study/Act)
- Flow Chart Analysis
- Cause-and-Effect Diagrams
- Brainstorming
- Observational Studies/patient flow
- Activity Logs

QI Team Improvements may include:

- System Redesign
- Education (Staff/Patients)
- Clinical Guidelines review, revision or development
- Procedure and policy changes

- Form development or revision

Each organization's QI Team will keep meeting records and utilize "The Testing Change (PDSA) Worksheet" to document progress on QI projects. All improvement plans will be communicated to all staff and to consumers affected by the change if deemed appropriate. All improvement plans will also be communicated to the State-wide QI Committee. Meetings, e-mails, memos, informal verbal communication are all considered appropriate methods to communicate the team's activities and improvement plans.

## F. Sustaining Improvements

Regular feedback regarding improvement projects is critical to its success in sustaining improvements over time. Once an improvement plan has been successful a regular monitoring schedule will be implemented to determine whether the plan remains successful over time. Each organization's QI Team will establish a calendar for monitoring improvement over time.

## G. Communicate results to relevant individuals and groups

The Manager of the HIV Care and Treatment Program will report the results of quality activities to the HIV/STI Section Chief. The Manager and the Quality Improvement Committee will also report the results of QI activities through the HIV Care Advisory Committee of the Colorado HIV/AIDS Care and Prevention Coalition, and may utilize the Colorado HIV/AIDS Planning Collaborative Committee to consider the implications of the QI activity results for Parts A services and possible implications for future collaboration.

## H. Evaluation and Revision of Statewide Quality Improvement Plan

The QI Committee and the QI Advance Team will conduct an annual evaluation of the QI Plan, including an evaluation of the QI infrastructure, QI activities, and performance measures, and identify areas for improving how QI work is being implemented.

The QI Committee will revise the Statewide Quality Improvement Plan on an annual basis.

## Glossary:

**Aim or Aim Statement**
A written, measurable, and time sensitive statement of the accomplishments a team expects to make from its improvement efforts. The Aim Statement contains a general description of the work, the system of focus, and numerical goals.

**Champion**
An individual in the organization or system who believes strongly in quality improvement and is willing to work with others to test, implement, and spread changes. This champion should have a good working relationship with colleagues and with leaders and be interested in driving change in the system.

**Change Concept**
A general idea for changing a process, usually developed by an expert panel based on literature and practical application of evidence. Change concepts are usually at a high level of abstraction, but evoke multiple specific ideas for how to change processes. "Simplify," "reduce handoffs," "consider all parties as part of the same system," are all examples of change concepts.

**Change Idea**
An actionable, specific idea for changing a process. Change ideas can be tested to determine whether they result in improvements in the local environment. An example of a change idea is: Simplify process for data entry by having front desk staff enter visit information daily from a duplicate copy while the original is filed in the chart.

**Colorado HIV/AIDS Planning Collaborative Committee**
The goal of this committee is to function as a joint committee for both the Denver HIV Resources Planning Council and Colorado HIV/AIDS Care and Prevention Coalition. The main purpose of this joint committee will be to collaborate on statewide HIV/AIDS care and treatment activities, as appropriate, and to develop necessary planning documents.

**Cycle**
See "PDSA Cycle."

**Data Collection Plan**
A specific description of the data to be collected, the interval of data collection, and the subjects from whom the data will be collected. The plan is included in all routine reports.

**Facilitator**
The Facilitator is the team member who is largely responsible for the administrative duties and logistics for the team as well as facilitating team meetings.

**Goal**
Broad statement(s) identifying a program's intentions about what they want to achieve.

**HIV Care Advisory Committee of the Colorado HIV/AIDS Care and Prevention Coalition**
CDPHE's Advisory Board. It advises and informs the department on issues, trends, needs and resources pertaining to HIV/AIDS in the State of Colorado in order to promote effective HIV care and prevention programs.

**HIV Care and Treatment Program Manager**
The Care and Treatment Program Manager oversees all HIV care programs and grants administered by the Colorado Department of Public Health and Environment.

**STI/HIV Section Chief**
The STI/HIV Section Chief oversees all STI and HIV programs and grants including prevention, testing, care services, and surveillance.

**Implementation**
Taking a change and making it a permanent part of the system. A change may be tested first and then implemented throughout the organization.

**Indicator (AKA Quality Indicator)**
A measurement tool or operational definition of one specific quality characteristic that can be measured (e.g., GYN exam, Treatment Plan) conforming to guidelines or standards of care. They are often categorized as either outcome or process indicator. It can also be called a measure, performance measure or quality measure.

**IS**
Refers to the information system of an organization or system, usually the computerized information system.

**Leader**
This person manages the team, assures tests are being completed, and data are collected. The day-to-day leader will be the critical driving component of the team, assuring that tests of change are implemented and overseeing data collection. It is important that this person understand not only the details of the system, but also the various effects of making change(s) in the system. The Team Leader will be the "key contact" of your team.

**Listserv**
A communication system that allows teams to stay connected with the Faculty and each other during the Action Periods. Sharing information, getting questions answered, and solving problems are all part of e-mail list activity.

**Measure**
A focused, reportable unit that will help a team monitor its progress toward achieving its Aim. There are many types of measures, including:

> ***Outcome measures*** are measures designed to show whether changes are leading to improvement for your client— that is, helping to achieve the overall aim of reducing complications and improving outcomes for people living with HIV and AIDS. Examples include reducing viral loads or increasing CD4 counts.
>
> ***Performance Measures*** are often used interchangeably with Quality Measures or Quality Indicators. Performance Measures are designed to measure the performance of the services provided by an organization or a grantee. A Performance measure is a carefully defined measure of a specific aspect of the program. Measures are chosen and prioritized based on Relevance, Measurability, Accuracy and Improvability

***Process Measures*** evaluate the workings of the system and answer the question: Are the parts/steps in the system performing as planned? Successful process measures will have a positive impact on your Outcome Measures.

***Structural Measures*** assess the characteristics and resources of an organization, such as staffing, supplies, equipment, and training. They attempt to understand the influence of physical surroundings, availability of services, and staffing mix on the quality and costs of care.

***System Measures*** are designed to measure the overall quality of care in a health system or within a grantee jurisdiction or multiple grantee jurisdictions. They function to align improvement work across multi-site and multidisciplinary provider networks.

**Model for Improvement**
An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the pace of change. The Model includes use of "rapid-cycle improvement," successive cycles of planning, doing, studying, and acting (PDSA Cycles).

**Objective**
Objectives state specific measureable accomplishments with a defined time frame. Usually begins with an action verb.

**PDSA Cycle**
Another name for a cycle (structured trial) of a change, which includes four phases: Plan, Do, Study, and Act. The PDSA Cycle will naturally lead to the "plan" component of a subsequent cycle.

**Quality Improvement Advance Team**
The Quality Improvement Advance Team is made up of CDPHE Staff and Quality Improvement Consultants. The team is responsible for implementing the QI Plan, gathering and managing data, reporting on findings, and supporting quality improvement projects.

**Quality Improvement Committee**
The Quality Improvement Committee (QI Committee) functions to centralize and coordinate quality improvement efforts across Ryan White contractors statewide. The committee membership is voluntary and may be composed of stakeholders from any of the Ryan White Parts, the ADAP Program, the HIV/STI surveillance team, liaisons from statewide contractors receiving Part B funds, Consumers, and the QI Advance Team. The QI Committee is responsible for reviewing the QI Plan, establishing shared quality measures, promoting collaboration among contractors, ensuring consumer involvement and means to influence the QI Plan, and supporting the development and implementation of improvement change activities.

**Quality Improvement Plan**
The Quality Plan is a written document that outlines an entity's HIV Quality Program, including a clear indication of responsibilities and accountability, performance measurement strategies and goals, and description of processes for ongoing evaluation and assessment of the Program.

**Quality Improvement Projects**

A quality improvement project is a project focused on making specific improvement in one area of focus (often called a "project problem statement") identified by the Quality Improvement Committee. A project brings together a team of people with diverse skills, experiences and insights. Each project has its own goals and measurable objectives.

**Run Chart**
A line chart showing results of improvement efforts plotted over time. The changes made are also noted on the line chart at the time they occur. This allows the viewer to connect changes made with specific results.

**Spread**
The intentional and methodical expansion of the number and type of people, units, or organizations using the improvements. The theory and application comes from the literature on the concept of Diffusion of Innovation.

**Team (AKA Quality Improvement Team)**
The group of individuals, usually from multiple disciplines, that drives and participates in the improvement process.

**Technical Expert**
The team member(s) in the system or organization who has a strong understanding of the process to be improved and changes to be made. A technical expert may also provide expertise in process improvement, data collection and analysis, and team function.

**Test**
A small-scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement, and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA Cycles.

# Appendix A

This section of the plan will guide the actual QI Committee work. This document is meant to be a working document, and will be adjusted as needed to meet the dynamic needs of CDPHE and their stakeholders.

Outlined in this appendix are the following:

1. Specific Indicators for Consideration (Note: once indicators are selected, these will be amended to include specific data collection methodologies and reporting details.)
   **Research and sources for the quality indicators:**
   - HAB clinical core indicators-Group 1 & 2 (hab.hrsa.gov/special/habmeasures.htm)
   - HAB Performance Measures Companion Guide-Scope of HAB Core Clinical Performance Measures (http://hab.hrsa.gov/special/performance/GuideScope08.htm)
   - Building Capacity of Statewide Quality Management Programs, NQC Guide for Ryan White HIV/AIDS Program Part B Grantees, Appendix E: Measures from Part B Collaborative (http://www.nationalqualitycenter.org/index.cfm/5659)
   - National HIVQUAL Project (www.HIVQUAL.org)
   - National Quality Center (NationalQualityCenter.org)
   - New York State Department of Health AIDS Institute (www.hivguidelines.org)
   - National Quality Measures Clearinghouse (www.qualitymeasures.ahrq.gov)
   - Institute for Health Care Improvement HIV Collaborative Measures
   - Other state QI Plans
2. Example of Measure Detail. Actual details to be developed once indicators finalized.
3. Example of Calendar format for quarterly QI meetings. Actual details to be developed once indicators and meeting dates finalized.

At present, indicators are matched with categories of focus in the following manner:

| | Access to Primary Care | Retention | Adherence | Access to Specialty Care | Building Capacity |
|---|---|---|---|---|---|
| Medical Case Management | x | X | x | x | x |
| ADAP | x | | x | | x |
| Insurance Programs | x | X | | | x |
| HIV Medical Care | x | X | x | | x |
| System Measures | x | | | | |

## Figure 1: Potential QI Indicators tied to Drivers

| # | Area of Focus | Drivers within Part B Control | Measure | Numerator/Denominator | Part B Service Type | Source/ comments |
|---|---|---|---|---|---|---|
| 3 (relates to 3 and 16) | **Access to High Quality Primary Care** | Insurance Assistance Program application process is user friendly and process timely | % of Insurance Assistance Program applications that were approved or denied for enrollment within two weeks of receiving a complete application in the measurement year. | Numerator: Number/% of Insurance Assistance Program applications that were approved or denied for enrollment within two weeks of receiving a complete application in the measurement year. Denominator: Total number of complete applications received in the measurement year. | Insurance | Modification of the HAB draft measure for ADAP |
| 5 (related 5,7) | **Access to High Quality Primary Care** | HIV-Care Providers deliver evidence-based care delivered by PHS guidelines | Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year. | Numerator: Number of HIV-infected clients who had 2 or more CD4/T-cell counts performed at least 3 months apart during the measurement year. Denominator: Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges [ 1 ], i.e. MD, PA, NP at least once in the measurement year. | PCP | HAB HIV Measure: Group 1. |
| 7 (related 5,7) | **Access to High Quality Primary Care** | Effective linkage and retention in care | Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year. | Numerator: Number of HIV-infected clients who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year. Denominator: Number of living HIV+ clients in the CDPHE surveillance system that have at least one CD4 count in the system. Measured at a point in time looking back one year.. | System | Surveilance System Data |
| 8 (related 6,8) | **Access to High Quality Primary Care** | Effective linkage and retention in care | Percentage of clients with HIV infection who had 2 or more viral loads performed in the measurement year. | Numerator: Number of HIV-infected clients who had 2 or more viral loads performed at least 3 months apart during the measurement year.<br><br>.Denominator: Number of living HIV+ clients in the CDPHE surveillance system that have at least one Viral Load count in the system. Measured at a point in time looking back one year. | System | Viral load Tend to correlate closely with measurement of CD4. Have to consider effort/benefit ratio. Surveillance System Data |

| | | | | | | |
|---|---|---|---|---|---|---|
| 11 | **Access to High Quality Primary Care** | Document and work to achieve Care Plan | % of HIV-infected medical case management clients who had medical case management care plan documented and updated two or more times at least three months apart in the measurement year. | Numerator: Number of HIV-infected medical case management clients who had a medical case management care plan documented and updated two or more times at least three months apart in the measurement year. Denominator: Number of HIV-infected medical case management clients who had at least one medical case management encounter in the measurement year. | MCM | HAB HIV Performance measures: Medical Case Management (draft) |
| 16 (related to 3 and 16) | **Adherence** | Can afford medications: ADAP application process is user friendly and process timely | % of ADAP applications that were approved or denied for ADAP enrollment within two weeks of ADAP receiving a complete application in the measurement year. | Numerator: Number % of ADAP applications that were approved or denied for ADAP enrollment within two weeks of ADAP receiving a complete application in the measurement year. Denominator: Total number of complete applications received in the measurement year. | ADAP | HAB HIV Performance Measures: ADAP (draft)<br><br>Measure from Part B Collaborative |
| 19 | **Building Capacity** | Organizations demonstrate effective actions to improve | % of organizations that demonstrate the ability to use data and QI methodologies to complete at least one Quality Improvement Project (look at improvement in one system) | Numerator: number of organizations who can demonstrate completion of one comprehensive Quality Improvement Project within the measurement year Denominator: Number of all participating organizations | All | Audited by Advance Team and consultants |
| 24 (related: 23, 24) | **Retention in Care** | Sees PCP at appropriate intervals | Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year. | Numerator: Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges [ 1 ], i.e. MD, PA, NP, in an HIV care setting [ 2 ] two or more times at least 3 months apart during the measurement year. Denominator: Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year | PCP | HAB HIV Performance measures, Group 1 |