Organizational Quality Assessment Tool

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STATE OF NEW YORK
DEPARTMENT OF HEALTH

nal Assessment:

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

This assessment identifies all of the important elements associated with a sustainable QMP. Scores from 0 to 5 are defined to identify gaps in the QMP and to set program priorities for improvement. The scoring structure measures program performance in specific domains along the spectrum of improvement implementation. When assigning a score of 0-5 for individual components, select the whole number that most accurately reflects organizational achievement in that area. If there is any uncertainty in assessing whether performance is closer to the statement in the next higher or next lower range, choose the lower score. Scoring is designed so that all items in a score must be satisfied to reach any one score for a component. Applied annually, this assessment will help a program evaluate its progress and guide the development of goals and objectives.

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

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

A. Quality Management

GOAL: To assess the HIV program infrastructure to support a systematic process with identified leadership, accountability and dedicated resources.

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

Leadership

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

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

Evidence of leadership support and engagement includes establishment of clear goals and objectives, communication of program/organizational vision, creating and sustaining shared values, and providing resources for implementation.

Quality Committee

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

Quality Plan

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

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

Each score requires completion of all items in that level and all lower levels (except any items in level 0)

Getting Started	0	☐ Senior leaders are not visibly engaged in the quality of care program.
Planning and initiation	1	Leaders are: ☐ Not fully involved in improvement efforts, quality meetings, supporting provision of resources for QI activities. ☐ Primarily focused on external requirements and supporting compliance with regulations. ☐ Inconsistent in use of data to identify opportunities for improvement.

Beginning Implementation	2	Leaders are: X☐ Not engaged optimally. X☐ Engaged in quality of care with focus on use of data to identify opportunities for improvement. X☐ Somewhat involved in improvement efforts. X☐ Somewhat involved in quality meetings. X☐ Supporting some resources for QI activities.
Implementation	3	Leaders are: ☐ Providing routine leadership to support the quality management program. ☐ Providing routine and consistent allocation of staff or staff time for QI (depending on facility size). ☐ Actively engaged in QI planning and evaluation. ☐ Actively managing/leading quality meetings. ☐ Clearly communicating quality goals and objectives to all staff. ☐ Recognizing and supporting staff involved in QI. ☐ Routinely reviewing performance measures and patient outcomes to inform program priorities and data use for improvement. ☐ Attentive to national health care trends/priorities that pertain to the program.
Progress toward systematic approach to quality	4	Leaders are: ☐ Supporting development of a culture of QI across the program, including provision of resources for staff participation in QI learning opportunities, seminars, professional conferences, QI story boards for distribution and drafting of scholarship, etc. ☐ Supporting prioritization of quality goals based on data, and critical areas of care are addressed in coordination with broader strategic goals for HIV care. ☐ Promoting patient-centered care and consumer involvement through the Quality Management Program. ☐ Routinely engaged in QI planning and evaluation. ☐ Routinely providing input and feedback to QI teams.
Full systematic approach to quality management in place	5	Leaders are: ☐ Actively engaged in the implementation and shaping of a culture of QI across the program, including provision of resources for staff participation in QI learning opportunities, seminars, professional conferences, QI story boards for distribution and drafting of scholarship, etc. ☐ Encouraging open communication through routine team meetings and dedicated time for staff feedback. ☐ Routinely and consistently engaged in QI planning and evaluation. ☐ Routinely and consistently providing input and feedback to QI teams. ☐ Encouraging staff innovation through QI awards or incentives. ☐ Directly linking QI activities back to institutional strategic plans and initiatives.

Commented [RS1]:

Comments: Our rating went from a 4 in 2019 to a 2 in 2020.

Although we have participation from administrative leadership and have had clinical leadership participation in the past year, we are currently in a state of transition due to the recent resignation of our medical director, who was overseeing both Santa Cruz and Watsonville. There is currently a Medical Director in Watsonville, who has not participated in our QM activities up to this point. Health Services Agency plans to hire a Medical Director in Santa Cruz. Discussions are taking place regarding how to better integrate Watsonville leadership into our RW Part C QM efforts, and the intention is for either or both of the Medical Directors to participate, once things have stabilized.

A.2. To what extent does the HIV program have an effective quality committee to oversee, guide, assess, and improve the quality of HIV services?

Getting Started	0	☐ A Quality Committee has not yet been developed or formalized or is not currently meeting regularly to provide effective oversight for the quality program.
Planning and initiation	1	The quality committee: ☐ May review data triggered by an event or problem or generated by donor or regulatory urging. ☐ Has minimally integrated quality activities into other existing meetings.
Beginning Implementation	2	The quality committee: ☐Has plans to hold regular meetings, but meetings may not occur regularly and/or do not focus on performance data. ☐ Has been formalized, representing most institutional disciplines. ☐ Has identified roles and responsibilities for participating individuals
Implementation	3	The quality committee: X☐ Is formally established and led by a program director, medical director or senior clinician. X☐ Has implemented a structured process to review data for improvement. X☐ Has defined roles and responsibilities as codified in the quality plan. X☐ Reviews performance data regularly, including staff and consumer satisfaction, if available. X☐ Discusses QI progress and redirects teams as appropriate
Progress toward systematic approach to quality	4	The quality committee: ☐ Is formally established and led by a program director, medical director or senior clinician specifically tasked with active oversight of the work of the quality program with established annual meeting dates. ☐ Represents all disciplines. ☐ Has established a performance review process to regularly evaluate clinical measures and respond to results as appropriate, including staff and consumer satisfaction. ☐ Communicates with non-members through distribution of minutes and discussion in regular staff meetings. Shares at HIV Advisory council ☐ Actively utilizes a workplan to closely monitor progress of quality activities and team projects. ☐ Provides progress reports to the organization-wide quality program.
Full systematic approach to quality management in place	5	The quality committee: ☐ Is a formal entity led by a senior clinician or administrator and, where appropriate, is linked to organizational Quality Committees through common members. ☐ Has established a systematic performance review process, including clinical, consumer satisfaction and operational measures to identify annual goals. ☐ Is responsive to changes in treatment guidelines and external/national priorities (NAHS, HAB, CMS), which are considered in development of indicators and choosing improvement initiatives. ☐ Has fully engaged senior leadership and they lead discussions during committee meetings. ☐ Effectively communicates activities, annual goals performance results and progress on improvement initiatives to all stakeholders, including staff, consumers and board members.

Comments: Our rating is the same in 2020 as it was in 2019 at a 3.

Although we have met most of the criteria to increase our rating to a 4, there are a few areas that we fall short. We currently do not have an HIV Advisory council that we share our QM activities with. We will need to explore how we might do that. Also, we have not consistently provided progress reports to the organization-wide quality program. In the past, the doctor who was leading our RW Part C QM efforts regularly attended the clinic quality meetings and updated the participants. We need to look at ways to better integrate RW Part C quality efforts with clinic wide quality efforts. This will likely happen as the RW Part C program transitions into clinics.

We also want to acknowledge that we have made some strides in our quality committee. We have a Nurse Case Manager and 2 MA's participating. We are utilizing a work plan with a QM calendar to monitor activities. We have begun to post QM activities on the HSA Intranet.

A.3. To what degree does the HIV program have a comprehensive quality plan that is actively utilized to oversee quality improvement activities?		
Each score requires completion of all items in that level and all lower levels (except any items in level 0)		
Getting Started	0	☐ A quality plan, including elements necessary to guide the administration of a quality program, has not been developed.
Planning and initiation	1	The quality plan: ☐ Is written with some of the essential components necessary to direct an effective quality program (see level 3). ☐ May be written for the parent organization or for the network, but plans specific to the HIV program or for the network has not yet been developed.
Beginning Implementation	2	The quality plan: ☐ Is written for the HIV program, and contains some of the essential components (see level 3). ☐ Is under review for approval (if required by organization) by senior leadership, and includes steps for implementation.
Implementation	3	The quality plan: X☐ Reflects an effective HIV-specific quality program with all of the essential QI components including: • annual goals and objectives, • roles, responsibilities, • logistics, • performance measurement and review processes, • QI methodology, • communication strategy, • consumer involvement, • program evaluation procedure X☐ Is routinely communicated to program staff. X☐ Includes an annual workplan/timeline outlining key activities of the quality program and improvement initiatives
Progress toward systematic approach to quality	4	The quality plan: Has been implemented and regularly used by the quality committee to direct the quality program. Includes annual goals identified on the basis of internal performance measures and external requirements through engagement of the quality committee and staff. Work plan is modified as needed to achieve annual goals. Is routinely communicated to stakeholders, including staff, consumers, board members and the parent organizations, if appropriate. Is evaluated annually by the quality committee to ensure that the needs of all stakeholders are met and that changes in the healthcare and regulatory environment are assessed to ensure that the program meets the changing needs of the HIV patient.
Full systematic approach to quality management in place	5	The quality plan: ☐ Is written, implemented and regularly utilized by the quality committee to direct the quality program and includes all necessary components (see level 3). ☐ Includes regularly updated annual goals that were identified by the quality committee using data on internal performance measures and external requirements through engagement of the quality committee and staff. ☐ Includes a workplan/timeline outlining key activities in place and is routinely and consistently used to track progress on performance measures and improvement initiatives, and modified as needed to achieve annual goals. ☐ Is aligned with that of the parent organization and/or all network sites, as appropriate.

Comments: Our rating went from a 2 in 2019 to a 3 in 2020. **We have an active plan from 2019 and final approval for our 2020 plan is pending approval by the QM Committee. Once approved, the plan will be sent to RW Part C staff. The plan will also be posted on the HIV intranet. We will also be discussing how to merge RW Part C QM intranet posts with clinic intranet posts.**

B. Workforce Engagement in the HIV quality program

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

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

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

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

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

Each score requires completion of all items in that level and all lower levels (except any items in level 0)

Getting Started	0	☐ All staff (clinical and non-clinical) are not routinely engaged in QI activities and are not provided training to enhance skills, knowledge, theory or methodology or encouragement to identify opportunities for improvement and develop effective solutions.
Planning and initiation	1	Engagement of core staff in QI (clinical and non-clinical): ☐ Is under development and includes training in QI methods and opportunities to attend meetings where QI projects are discussed.
Beginning Implementation	2	Engagement of core staff in QI (clinical and non-clinical): XIs underway and some staff have been trained in QI methodology. XIncludes QI meetings attended by some designated staff.
Implementation	3	Engagement of core staff in QI (clinical and non-clinical) includes: ☐ Attendance in at least one training in QI methodology. Staff members are generally aware of Program QI activities (quality plan/priorities). ☐ Involvement in QI projects, project selection and participation in a QI committee. ☐ QI project development, where projects are discussed and reviewed during staff meetings. ☐ Defined roles and responsibilities related to QI. Physicians and staff are aware of the quality plan and priorities for improvement. ☐ A formal process for regularly recognizing staff performance in QI via performance appraisals, public recognition during staff meetings, etc.
Progress toward systematic	4	Engagement of core staff in QI (clinical and non-clinical) includes: ☐ Demonstrated evidence that staff members are engaged and encouraged to use those skills to

approach to quality		identify QI opportunities and develop solutions. ☐ A shared language regarding quality, which is evidenced in routine discussion. ☐ Description in the annual quality plan, and includes staff training and roles and responsibilities regarding staff involvement in QI activities and use in staff performance evaluation ☐ A formal process for recognizing staff performance internally and QI teams are provided opportunities to present successful projects to all staff and leadership.
Full systematic approach to quality management in place	5	<u>Engagement of core staff in QI (clinical and non-clinical) includes</u>: ☐ Staff awareness of the importance of quality and continuous improvement, and their participation in identifying QI issues, developing strategies for improvement and implementing strategies. ☐ Regular and continuous QI education and training in QI methodology. ☐ Leadership who encourages all staff to make needed changes and improve systems for sustainable improvement including the necessary data to support decisions. ☐ Formal and informal discussions where teamwork is openly encouraged and leadership shapes teamwork behavior. ☐ Routine communication about new developments in QI, including promotion of QI projects both internally (e.g., quality conferences) and externally (e.g., related conferences). ☐ Opportunities for abstract development and submission to relevant professional conferences and authorship of related publications about development and **had some help from Alliance with overall QI efforts for a while. The intention is to bring Alliance back in** implementation of institutional QM programs.
Comments: Our rating is the same in 2020 as it was in 2019 at a 2. **We have begun implementation of most of the criteria in the implementation phase. We are looking at how we can enhance staff QI training. Alliance previously provided consultation and training to the overall agency QI efforts. The agency QM Council is looking to bring Alliance support back in to provide training to all clinic staff, which will include RW Part C staff.** **As the RW Part C program gets more integrated into clinics, we plan to get more specific in defining roles and responsibilities relate to QI.** **We will also look at ways to acknowledge staff performances in QI efforts.**		
B.2. To what extent is staff satisfaction included as a component of the quality management program?		
Each score requires completion of all items in that level and all lower levels (except any items in level 0)		
Getting Started	0	☐ There is no mechanism in place to assess and address staff satisfaction.
Planning and initiation	1	<u>Staff satisfaction</u>: X☐ Is assessed through informal discussion with some staff.
Beginning Implementation	2	<u>Staff satisfaction</u>: ☐ Is part of a formal process that includes at least one staff satisfaction survey.
Implementation	3	<u>Staff satisfaction</u>: ☐ Is part of a formal process where information is utilized to determine opportunities for improvement. ☐ Survey results are reviewed with staff and areas for improvement identified.
Progress toward systematic approach to quality	4	<u>Staff satisfaction</u>: ☐ Survey results are reviewed with staff, areas for improvement identified, and planning is underway/work has begun to utilize this information to improve work conditions within the program.

Full systematic approach to quality management in place	5	Staff satisfaction: ☐ Is measured in multiple ways (surveys, performance reviews) and information is utilized to improve work conditions within the ability of the program. ☐ Survey results lead to improvement projects or activities through findings. Issues raised through staff feedback are prioritized in plans for improvement. ☐ Is characterized by staff directed QI project teams initiated based on data analysis, with updates regularly communicated to leadership and all staff members.

Comments: Our rating is the same in 2020 as it was in 2019 at a 1.
We completed our final edit of the Staff Satisfaction Survey during this review, and it will be sent out shortly.

C. Measurement, Analysis and Use of Data to Improve Program Performance ***GOAL: To assess how the HIV program uses data and information to identify opportunities for improvement, develops measures to evaluate the success of change initiatives, to align initiatives, and to monitor program status; and to ensure that accurate, timely data and information are available to stakeholders throughout the organization to drive effective decisions*** The Measurement, Analysis and Use of Data section assesses how the program selects, gathers, analyzes and uses data to improve performance. This includes how leaders conduct performance reviews to ensure that actions are taken, when appropriate, to achieve program goals.		
C.1. To what extent does the HIV program routinely measure performance and use data for improvement?		
Each score requires completion of all items in that level and all lower levels (except any items in level 0)		
Getting Started	0	☐ Performance measures have not been identified.
Planning and initiation	1	Performance measures: ☐ Have been identified to evaluate some components of the program, but do not cover all significant aspects of service delivery. ☐ Are defined and used by personnel at some but not all units or sites. Performance data: ☐ Collection is planned pending initiation.
Beginning Implementation	2	Performance measures: ☐ Are externally defined and used by personnel at all applicable sites. Performance data: ☐ Validation, analysis and interpretation of results on measures are in early stages of development and use. ☐ Results are occasionally shared with staff and patients.
Implementation	3	Performance measures: X☐ Are externally defined or required (e.g., HAB, HIVQUAL), with the intent to meet external regulatory requirements and the needs of stakeholders, including patients. X☐ Are defined and consistently used by personnel at all applicable sites. Performance data: X☐ Are tracked, analyzed and reviewed with the frequency required to identify areas in need of improvement. A structured review process is used regularly by the leadership to identify and prioritize improvement needs and initiate action plans to ensure that goals are achieved. X☐ Are collected by staff with working knowledge of indicator definitions and their application. X☐ Results and associated measures are routinely shared with staff and their input is elicited to make improvements.
Progress toward systematic approach to quality	4	Performance measures: ☐ Are externally defined or required (e.g., HAB, HIVQUAL) and tied to annual organizational goals, with the intent to meet external regulatory requirements and the needs of stakeholders and patients, and goals of alignment with current evidence in the diagnosis and treatment of HIV. ☐ Reflect priorities of clinic staff and patients, in consideration of local issues. Performance data: ☐ Results and associated measures are frequently shared with staff to elicit their input and engage them in improvement processes aligned with organizational goals.
Full systematic approach to quality management in place	5	Performance measures: ☐ Are selected using organizational annual goals, with the intent to meet external regulatory requirements as well as the needs of stakeholders and patients, and goal of alignment with current evidence in the diagnosis and treatment of HIV. ☐ Reflect priorities of clinic staff and patients, in consideration of local issues.

		☐ Are defined for each program component and actively used to drive improvement activities. ☐ Are evaluated regularly to ensure that the program is able to respond effectively to internal and external changes quickly.
		Performance data: ☐ Are visible or easily accessible to ensure data reporting transparency throughout the clinic. ☐ Are arrayed in formats that enable accurate interpretation, such as run charts and/or control charts. ☐ Results and associated measures are systematically shared with all stakeholders, including staff, patients and boards to elicit their input and engage them in improvement processes aligned with organizational goals.

Comments: Our rating in 2020 is the same as it was in 2019 at a 3.
We need to work on a formal process that will help us to ensure that we are getting feedback from staff and patients that reflects their priorities in consideration of local issues.
We have made strides in increasing staff engagement in the performance measures improvement process. QI updates are shared with the CARE Team at staff meetings, and there are more clinic staff on our QM committee. We need to improve the sharing of QM results with Watsonville staff, and increase all staff engagement in the improvement process.

D. Quality Improvement Initiatives

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

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

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

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

Each score requires completion of all items in that level and all lower levels (except any items in level 0)

Getting Started	0	☐ Formal quality improvement projects have not yet been initiated in the program.
Planning and initiation	1	QI initiatives: ☐ No assessment of organizational performance or system level analysis of data performed; are not team-based and do not use specific tools or methodology. ☐ Focus on individual cases only. ☐ Reviews are primarily used for inspection.
Beginning Implementation	2	QI initiatives: ☐ Are prioritized by the quality committee based on program goals, objectives and analysis of performance measurement data. ☐ Involve team leaders and team members who are assigned by the quality committee or other leadership. ☐ Begin to use specific tools or methodology to understand causes and make effective changes.
Implementation	3	QI initiatives: ☐ Are ongoing based on analysis of performance data and other program information, including external reviews and assessments. ☐ Focus on processes of care in which QI methodology is routinely utilized.

		☐ Are regularly documented and provided to Quality Improvement Committee. ☐ Involve staff on QI teams. Cross departmental/cross functional teams are developed depending on specific project needs.
Progress toward systematic approach to quality	4	QI initiatives: X☐ Reflect input from staff through a transparent process. X☐ Routinely and consistently reinforce and promote a culture of quality improvement throughout the program through shared accountability and responsibility of identified improvement priorities. X☐ Are supported with appropriate resources to achieve effective and sustainable results. X☐ Involve support of data collection with results routinely reported to QI project teams.
Full systematic approach to quality management in place	5	QI initiatives: ☐ Are ongoing in every service category. ☐ Correspond with a structured process for prioritization based on analysis of performance data and other factors. ☐ Are implemented by project teams. Further, physicians and staff can identify an improvement opportunity at any point in time and suggest a QI team be initiated. ☐ Consistently and routinely utilize robust process improvement and multidisciplinary teams to identify actual causes of variation and apply effective sustainable solutions. ☐ Are guided by a team leader or sponsor, and include all relevant staff depending on specific project needs. ☐ Are regularly communicated to the Quality Committee, staff and patients. ☐ Routinely involve consumers on QI project teams. ☐ Are presented in storyboard context or other formats and reported to larger organization and/or placed in public areas for staff and patients (if relevant). ☐ Involve recognition of successful teamwork by senior leadership. ☐ Are supported by development of sustainability plans.

Comments: Our rating went from a 3 in 2019 to a 4 in 2020.
We have more diversified staff on the QM committee and we are regularly doing PDSA projects.

E. Consumer Involvement

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

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

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

Each score requires completion of all items in that level and all lower levels (except any items in level 0)

Getting Started	0	☐ There is currently no process to involve consumers in HIV quality management program activities.

Planning and Initiation	1	Consumer involvement: ☐ No formal process is in place for ongoing and systematic participation in quality management program activities. ☐ Is occasionally addressed by soliciting consumer feedback.
Beginning Implementation	2	Consumer involvement: ☐ Is addressed by soliciting consumer feedback, with development of a formal process for ongoing and systematic participation in quality management program activities.
Implementation (Meets HAB requirements)	3	Consumer involvement: X☐ Includes engagement with consumers to solicit perspectives and experiences related to quality of care. X☐ Is formally part of HIV quality management program activities through a formal consumer advisory committee, satisfaction surveys, interviews, focus groups and/or consumer training/skills building. However, the extent to which consumers participate in quality management program activities is not documented or assessed.
Progress toward systematic approach to quality	4	Consumer involvement: ☐ Is part of a formal process for consumers to participate in HIV quality management program activities, including a formal consumer advisory committee, surveys, interviews, focus groups and/or consumer training/skills building. ☐ In improvement activities includes three or more of the following: – sharing performance data and discussing quality during consumer advisory board meetings – membership on the internal quality management team or committee – training on quality management principles and methodologies – engagement to make recommendations based on performance data results – increasing documentation of recommendations by consumers to implement quality improvement projects. ☐ Information gathered through the above noted activities is documented and used to improve the quality of care.
Full systematic approach to quality management in place	5	Consumer involvement: ☐ Contribution and its impact on quality is reviewed with consumers. ☐ Is part of a formal, well-documented process for consumers to participate in HIV quality management program activities, including a consumer advisory committee with regular meetings, consumer surveys, interviews, focus groups and consumer training/skills building. ☐ In quality improvement activities includes four or more of the items bulleted in E2#4. ☐ Information gathered through the above noted activities is documented, assessed and used to drive QI projects and establish priorities for improvement. ☐ Includes work with program staff to review changes made based on recommendations received with opportunities to offer refinements for improvements. Information is gathered in this process and used to improve the quality of care. ☐ Involves at minimum, an annual review by the quality management team/committee of successes and challenges of consumer involvement in quality management program activities to foster and enhance collaboration between consumers and providers engaged in quality improvement.

Comments: Our rating went from a 2 in 2019 to a 3 in 2020. Our plan is to have 3 consumer forums annually (so far we had 2 in the past year). We will have another one after the pandemic crisis passes. We have begun to distribute Consumer Surveys, and have gotten some responses, but will need to wait until after the pandemic crisis passes to get enough responses to ensure that we are getting a statistically significant number.

F. Quality Program Evaluation ***GOAL: To assess how the program evaluates the extent to which it is meeting the identified program goals related to quality improvement planning, priorities and implementation.*** Quality program evaluation can occur at any point during the cycle of quality activities, but should occur annually at a minimum. The process of evaluation should be linked closely to the quality plan goals: to assess what worked and what did not, to determine ongoing improvement needs and to facilitate planning for the upcoming year. The evaluation examines the methodology, infrastructure and processes, and assesses whether or not these led to expected improvements and desired outcomes. At a minimum, the evaluation should assess access to data to drive improvements, success of QI project teams; and effectiveness of quality structure. Where appropriate, external evaluations and assessments should be utilized in partnership with the internal evaluation. The evaluation is most effectively performed by program leadership and the program's quality committee, optimally with some degree of consumer involvement.		
F.1. Is a process in place to evaluate the HIV program's infrastructure and activities, and processes and systems to ensure attainment of quality goals, objective and outcomes?		
Each score requires completion of all items in that level and all lower levels (except any items in level 0)		
Getting Started	0	☐ No formal process is established to evaluate the quality program.
Planning and Initiation	1	Quality program evaluation: ☐ To assess program processes and systems is exclusively external.
Beginning Implementation	2	Quality program evaluation: X☐ Is part of a formal process and is integrated into annual quality management plan development
Implementation	3	Quality program evaluation: ☐ Occurs annually, conducted by the quality committee, and includes QM plan and workplan updates and revisions. ☐ Involves annual (at minimum) revision of quality goals and objectives to reflect current improvement needs. ☐ Results are used to plan for future quality efforts. ☐ Includes a summary of improvements and performance measurement trends to document and assess the success of QI projects. ☐ Results, noted above, are shared with consumers and other key stakeholders.
Progress toward systematic approach to quality	4	Quality program evaluation: ☐ Findings are integrated into the annual quality plan and used to develop and revise program priorities. ☐ Is reviewed during quality committee meetings to assess progress toward planning goals and objectives. ☐ Includes review of performance data, which is used to inform decisions about potential changes to measures. ☐ Is used to determine new performance measures based on new priorities. ☐ Includes analysis of QI interventions to inform changes in program policies and procedures to support sustainability.
Full systematic approach to quality management in place	5	Quality program evaluation: ☐ Findings are integrated into routine program activities as part of a systematic process for assessing quality activities, outcomes and progress toward goals. Data and information is provided regularly to the quality committee. ☐ Is used by the quality committee to regularly assess the success of QI project work, successful interventions and other markers of improved care. ☐ Includes data reflecting improvement initiatives, and is presented to ensure comprehensive analysis of all quality activities.

		☐ Uses a detailed assessment process. The results of this assessment are utilized to revise and update the annual quality plan; adjust the HIV program priorities; and identify gaps in the program. ☐ Includes an analysis of progress towards goals and objectives and QI program successes and accomplishments. ☐ Describes performance measurement trends which are used to inform future quality efforts. ☐ Communicates evidence that QI efforts informed through this process resulted in measureable improvement.

Comments: Our rating in 2020 is the same as it was in 2019 at a 2.
We have met most of the criteria for implementation (3), but we could do a better job of sharing our results with consumers and other key stakeholders. We can look at the possibility of sharing results at consumer forums and we need to ensure that we are regularly posting results on the intranet.

G. ACHEIVEMENT OF OUTCOMES

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

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

*Possible data sets for comparison include HIVQUAL, HAB, In+Care Campaign, Regional groups, RSR, VA, Kaiser, HIVRAD

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

Each score requires completion of all items in that level and all lower levels (except any items in level 0)

Getting Started	0	☐ No clinical performance results are routinely reviewed or used to guide improvement activities.
Planning & Initiation	1	Data: ☐ For some measures are routinely reviewed and used to guide improvement activities. ☐ Trends for some measures are reported to determine improvement over time.
Beginning Implementation	2	Data: X☐ Results for most measures are routinely reviewed and used to guide improvement activities. X☐ Trends for most measures are reported and many show improving trends over time.
Implementation	3	Data: ☐ Results for all measures are routinely reviewed and used to guide improvement activities, including Viral Load Suppression and Retention in Care. ☐ Trends for all measures are reported and many show improving trends over time. ☐ Results are compared to a larger aggregate data set for at least 2 outcome measures: Viral Load suppression and Retention in care. ☐ Comparison to larger aggregate data set is used to set programmatic targets.
Progress toward systematic approach to quality	4	Data: ☐ Comparison to larger aggregate data set are used to set programmatic targets and targets are met for at least 50% of measures. ☐ Results for Viral Load Suppression and Retention in Care scores are equal to or greater than the 75th percentile of comparative data set.

Full systematic approach to quality management in place	5	Data: ☐ Trends are reported for all measures and most show sustained improvement over time in areas of importance aligned with organizational goals. ☐ Comparison to larger aggregate data set are used to set programmatic targets and targets are met for at least 75% of measures. ☐ Results for Viral Load Suppression and Retention in Care scores are above the 75th percentile of comparative data set.

Comments: Our rating went from a 3 in 2019 to a 2 in 2020.
We have not been formally looking at aggregate data, except for the organization-wide UDS aggregate data, which includes HIV linkage to care. Our goal is to ensure that we are formally looking at and documenting our aggregate data for viral load suppression and to integrate the organization HIV linkage to care aggregate data.

G.2. Reduction in Disparities in HIV Care

GOAL*: *To assure that all patients receive the same level of quality services and resulting health outcomes regardless of their exposure category, race/ethnicity, gender, age or economic status.

This section assesses the program's ability to assure that all patients, regardless of their exposure category, race/ethnicity, gender, age or economic status, receive the same level of quality care. In order to achieve equity in quality and outcomes for all patients, a system for consistent review of data stratified by these factors, and evidence of actions taken for any disparities identified would be needed.

G.2. To what extent does the HIV program measure disparities in care and patient outcomes, and use performance data to improve care to eliminate or mitigate discernible disparities ?

Each score requires completion of all items in that level and all lower levels (except any items in level 0)

Getting Started	0	X☐ No clinical performance results are routinely reviewed or used to address disparities.
Planning & Initiation	1	Performance measures/data: ☐ Are stratified for analysis of disparities by gender, age, SES, risk factor, geography, etc.
Beginning Implementation	2	Performance measures/data: ☐ Are used to identify disparities ☐ Are used to plan improvement strategies
Implementation	3	Performance measures/data: ☐ Are used to develop and implement general improvement strategies
Progress toward systematic approach to quality	4	Performance measures/data: ☐ Are used to develop and implement general and targeted improvement strategies based on data analysis ☐ Demonstrate some evidence of improvement of outcomes for identified disparities
Full systematic approach to quality management in place	5	Performance measures/data: ☐ Demonstrate sustained evidence of improvement of outcomes for identified disparities

Comments: Our results are the same in 2020 as 2019 at a 0.
Other than comparing Santa Cruz to Watsonville (which have some race/ethnicity differences), we have not used performance data to measure disparities in care and patient outcomes. Our goal is to do a PDSA to look at this, with the outcome possibly being viral load suppression.

Summary of Results

Comments By: ___Robin Stone, RN_________________________________
Date: _3/20/20_____________

What are the major findings from the Organizational Assessment?*
Please number and link all findings with key recommendations and suggestions. Major findings should address all components with a score below 3.

Please refer to the comment section of each question. I will review any findings below a 3 in this section.

A.1. To what extent does senior leadership create an environment that supports a focus on improving the quality of HIV care?
Our rating went from a 4 in 2019 to a 2 in 2020.
Although we have participation from administrative leadership and have had clinical leadership participation in the past year, we are currently in a state of transition due to the recent resignation of our medical director, who was overseeing both Santa Cruz and Watsonville. There is currently a Medical Director in Watsonville, who has not participated in our RW Part C QM activities up to this point. Health Services Agency plans to hire a Medical Director in Santa Cruz. Discussions are taking place regarding how to better integrate Watsonville leadership into our RW Part C QM efforts, and the intention is for either or both of the Medical Directors to participate, once things have stabilized.

B.1. To what extent are physicians and staff routinely engaged in quality improvement activities and provided training to enhance knowledge, skills and methodology needed to fully implement QI work on an ongoing basis?
Our rating is the same in 2020 as it was in 2019 at a 2.
We have begun implementation of most of the criteria in the implementation phase (3). The agency QM Council had some help from Alliance with overall QI efforts for a while. The intention is to bring Alliance back in to provide training to all clinic staff, which will include RW Part C staff.
As the RW Part C program gets more integrated into clinics, we plan to get more specific in defining roles and responsibilities relate to QI.
We will also look at ways to acknowledge staff performances in QI efforts.

B.2. To what extent is staff satisfaction included as a component of the quality management program?
Our rating is the same in 2020 as it was in 2019 at a 1.
We completed our final edit of the Staff Satisfaction Survey during this review, and it will be sent out shortly.

F.1. Is a process in place to evaluate the HIV program's infrastructure and activities, and processes and systems to ensure attainment of quality goals, objectives and outcomes?
Our rating in 2020 is the same as it was in 2019 at a 2.
We have met most of the criteria for implementation (3), but we could do a better job of sharing our results with consumers and other key stakeholders. We can look at the possibility of sharing

results at consumer forums and we need to ensure that we are regularly posting results on the intranet.

G.1. To what extent does the HIV program monitor patient outcomes and utilize data to improve patient care?
Our rating went from a 3 in 2019 to a 2 in 2020.
We have not been formally looking at aggregate data, except for the organization-wide UDS aggregate data, which includes HIV linkage to care. Our goal is to ensure that we are formally looking at and documenting our aggregate data for viral load suppression and to integrate the organization HIV linkage to care aggregate data.

G.2. To what extent does the HIV program measure disparities in care and patient outcomes, and use performance data to improve care to eliminate or mitigate discernible disparities?
Our results are the same in 2020 as 2019 at a 0.
Other than comparing Santa Cruz to Watsonville (which have some race/ethnicity differences), we have not used performance data to measure disparities in care and patient outcomes. Our goal is to do a PDSA to look at this, with the outcome possibly being viral load suppression.

What are the key recommendations and suggestions? What specific areas should be improved? What are specific improvement goals for the upcoming year?

Please include associated timeframe for each recommendation and improvement goal. Recommendations and areas in need of improvement should address all components with a score below 3.

PRIORITIES/GOALS FOR THE YEAR

1. Improve data collection and analysis and utilize in program development
2. Clarify and update performance measures-ongoing
3. Continue to work on increasing consumer participation
4. Continue to initiate quality activities based on data outcomes such as PDSAs
5. Perform a functional evaluation of the CQM program
6. Support the transition of RW Part C QM from Public Health to Clinics

ADDITIONAL RECOMMENDATIONS

1. As the RW Part C program transitions from Public Health to Clinics, define roles and responsibilities of staff related to QI.- Ongoing
2. Improve integration of Watsonville Health Clinic into RW Part C quality activities-Ongoing
3. Improve overall staff QI training and engagement-Ongoing
4. Send Staff Satisfaction Survey to RW Part C staff and elicit feedback within 2 weeks of date sent- To be completed by April 15, 2020
5. Improve communication regarding QI activities with key stakeholders and consumers-Ongoing
6. Devise a formal mechanism to compare our RW Part C performance results with aggregate data for HIV linkage to care and VL suppression-To be completed by 5/31/20
7. Do a PDSA to measure disparities in care and patient outcomes. Use performance measure data to implement improvement strategies.- Initiate PDSA by 6/1/20

Program Information Organizational Quality Assessment Tool

HIV PROGRAM NAME: ______________________________

Contact Person Name: ______________________________

Contact Email/Phone: ______________________________

Main Program Address: ______________________________

City State: Zip Code:

Fax:

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

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

Type of Facility* *Select One* (for Part C and/or D funded):
☐ FQHC ☐ Community-based Clinic (non-FQHC)
☐ University Hospital ☐ Other Hospital ☐ Other

Type of Facility* *Select One* (for NYS only):
☐ Community Health Center ☐ Drug Treatment Center
☐ Designated AIDS Center ☐ Hospital (non-DAC)

*For NYS facilities that receive Part C and/or D funding, please complete both sections.

Funding Source(s): *Check all that apply*
☐ RW Part A ☐ RW Part B ☐RW Part C ☐ RW Part D ☐ AETC
☐ Non-RW State-Initiated Grants ☐ Other HIV Grants: ________________________

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

Other: ____

HIV Care Delivery: ☐ Separate location and time ☐ Separate only by time
☐ Fully Integrated into general primary care

Staffing:
☐ FT HIV Medical Director ☐ FT HIV Administrator
☐ FT HIV Quality Manager If not FT, ____ % HIV Quality Manager
Background of Q Manager: ☐ MD ☐ Nurse ☐ PA ☐Other_____________________
___ FTEs HIV Clinical Providers (NP, PA, MD)
___ FTEs HIV Case Managers ☐ Other access to MIS Staff
___ FTE Data manager ___ FTEs: Other HIV staff

HIVQUAL Data Submission in Most Recent Data Cycle: ☐ Yes ☐ No ☐ N/A*

* N/A only applies to programs that joined HIVQUAL-US during the most recent data cycle and were unable to participate in the submission).

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

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

____
____
____
____
____

Survey Completed: Name: ______________________ Date: ______________

Assessment: ☐ baseline ☐ annual If new, HIVQUAL site since: /

Additional Questions

1) Regarding your facility's use of an electronic health record (EHR) system,* select one of the following:

___An EHR system for HIV Primary Care has been implemented.
Please specify the EHR vendor: ______________

___We have committed to an EHR.
Please specify the EHR vendor: ______________

___We are choosing between vendors.
Please specify which vendors are being considered:
____

___We are not investigating using an EHR vendor.

*Please note, CAREWare and Lab Tracker are not EHR systems.

2) Does your facility use CAREWare or another database/software program to manage and/or monitor HIV care?

___CAREWare

___Different database or software program

Please specify: ______________

3) Has your facility applied for certification as a Patient-Centered Medical Home?

NCQA Level 1 applied _____

NCQA Level 2 applied _____

NCQA Level 3 applied _____

Do not know level applied _____

Have not applied _____

4) If your facility has applied for certification as a Patient-Centered Medical Home, has your facility been approved?

NCQA Level 1 approved _____

NCQA Level 2 approved _____

NCQA Level 3 approved _____

Do not know level approved _____

Have not been approved _____