Ryan White HIV/AIDS Program
Clinical Quality Management
Quality Improvement Project Interactive Project

✅Section 1: Project Details

Clearly define the foundational details of your QI project to ensure clarity, feasibility, and alignment with your agency's capacity. This section sets the tone for the rest of your QI plan — it should clearly communicate what, where, and when your project will happen.

🧾Key Definitions

- **Project Title**: A short, descriptive name summarizing what your project aims to improve.
- **Project Dates**: A defined start and end period. The timeline should be realistic, allowing enough time for planning, testing changes, collecting data, and making adjustments.
- **Project Location**: The exact site(s) where your project will take place (e.g., name of your agency, clinic site, specific program area). Be specific — this helps clarify the project's scope and responsible parties.

📝Guided Prompts for Completing Section 1

Project Title:

- What specific improvement is your project trying to achieve?
- Can someone outside your organization understand what your project is about by reading this title?

Project Dates:

- When will the project start and end?
- Have you allowed time for all four phases of the QI cycle: plan, do, study, and act?
- Is the timeline realistic, given your agency's capacity and other obligations?

Project Location:

- Where exactly will your project be implemented?
- Is this a single program, department, or site — or multiple? Be specific.

📋Example

Project Title:

Increasing Rapid Linkage to Care for Newly Diagnosed Hispanic/Latino Clients

Project Dates:

May 1, 2025 – December 31, 2025

Project Location:
XYZ Community Health Center, Paterson, NJ – HIV Testing and Counseling Department

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📌Reflective Checkpoint Before Finalizing Section 1

✅ Does your project title clearly communicate what your QI project is about?

✅ Are your project dates feasible, allowing enough time to collect data and test improvements?

✅ Is your location specific enough that someone unfamiliar with your agency would know exactly where the project will happen?

✅ Section 2: Problem Statement (5Ws Framework)

The problem statement sets the stage for your entire quality improvement project. A strong problem statement clearly defines the *gap* between the current state and the desired future state. It should be rooted in **data**, informed by **client/staff experience**, and narrow enough to be actionable.

🧾 Key Definitions – The 5Ws Framework

Use the 5Ws to craft a clear and comprehensive problem statement:

- **Who**: Which clients, staff, or stakeholders are directly affected?
- **What**: What specific problem, barrier, or gap is occurring?
- **When**: When does the issue typically arise or peak?
- **Where**: Where within your system, service, or workflow is the problem occurring?
- **Why**: Why is this issue happening — what are the suspected or known root causes?

This framework ensures your statement includes **both context and urgency**, helping you and others understand why the issue matters and how it impacts care.

📝 Guided Prompts for Writing Your Problem Statement

Use the questions below to build a clear and focused problem statement:

Who:
- Which population is most impacted (e.g., Hispanic/Latino clients, transgender individuals)?
- Are staff also affected by this problem (e.g., case managers facing delays)?

What:
- What is the exact issue you are trying to improve?
- Is there a **measurable gap** or trend (e.g., low retention, delayed linkage, missed follow-ups)?

When:
- At what point in the service process does this problem occur?
- Is it ongoing or does it spike during specific times?

Where:
- Where exactly is the issue observed (clinic, intake, referral process, eligibility system)?

Why:
- What do you suspect are the contributing factors?
- Are there known causes like staffing challenges, documentation burdens, and communication gaps?

📋 Example

Problem Statement:
Hispanic/Latino clients newly diagnosed with HIV at community-based testing sites are experiencing delays of more than 7 days in being linked to HIV medical care. These delays often occur during the handoff between testing staff and case managers. Root causes may include limited bilingual staff, unclear referral protocols, and lack of real-time communication between agencies.

📌 Reflective Checkpoint Before Finalizing Your Problem Statement

✅ Does your problem statement identify *who* is affected and *how*?

✅ Have you included measurable indicators or specific observations (e.g., number of days delayed, % of clients lost)?

✅ Have you identified suspected root causes (even if they'll be validated later)?

✅ Is your problem statement narrow and specific enough to be addressed within the 8-month project period?

✅ Section 3: Aim Statement (SMARTIE Goals Framework)

Your aim statement defines **what success looks like**. It should be bold, measurable, time-bound, and directly aligned with the core issue you've identified in your problem statement. The **SMARTIE** framework ensures that your goal also explicitly promotes **inclusion and equity** — critical values in Ryan White HIV/AIDS Program work.

🧾 SMARTIE Goals Definitions

- **Specific** – Clearly describe *what* you want to accomplish.
- **Measurable** – Include a numeric target or data point to track progress.
- **Achievable** – Set a goal that is realistic based on current capacity and resources.
- **Relevant** – Align your goal with agency priorities, strategic direction, and client needs.
- **Time-bound** – Set a clear timeframe or deadline for achieving your goal.
- **Inclusive** – Ensure you are considering diverse perspectives, especially from those most impacted.
- **Equitable** – Focus on closing gaps or addressing disparities in health outcomes or access.

📝 Guided Prompts for Writing Your SMARTIE Aim Statement

Specific (S):

- What exactly will your project achieve?
- Clearly define the population, process, or outcome you are targeting.

Measurable (M):

- How will you know the goal is met?
- What specific metric will you track (e.g., % of clients linked to care, viral suppression rate)?

Achievable (A):

- Is this goal realistic for your team, time, and resources?
- Why do you believe this goal can be achieved during the project period?

Relevant (R):

- How does this goal align with client needs or agency priorities?
- What organizational or community challenges does this help address?

Time-bound (T):

- By when will this goal be achieved?
- Does the timeline align with the QIP period (May 1–Dec 31, 2025)?

Inclusive (I):

- Who will be involved in the planning, implementation, and feedback process?
- How will you ensure participation from priority populations or people with lived experience?

Equitable (E):

- Which disparities will this project aim to reduce?
- How does this goal help close gaps in outcomes for underserved communities?

📋 Example of a Good SMARTIE Goal

By December 31, 2025, we will improve viral suppression rates among transgender clients from 65% to 80% by implementing culturally responsive adherence counseling and peer navigation services. We will engage transgender clients through peer-led support groups and include their feedback in program adjustments. This goal aims to reduce the viral suppression disparity between transgender clients and the overall client population.

📌 Reflective Checkpoint Before Finalizing Your SMARTIE Goal

✅ Have you clearly identified *who* and *what* the goal targets?
✅ Is the goal **measurable** with a specific indicator or outcome?
✅ Is it realistically **achievable** within 8 months?
✅ Does it support your agency's mission and priorities?
✅ Is the **timeline** clearly stated and aligned with the project period?
✅ Have you included strategies to ensure voices from **impacted communities** are heard and involved?
✅ Have you clearly stated how the project will help reduce **disparities**?

✅ Section 4: Rationale

Your rationale explains **why this QI project matters right now**. This section should connect the dots between the problem, the goal, and the **impact** — on clients, staff, and your agency. A well-written rationale strengthens the *urgency*, *strategic relevance*,

and *equity focus* of your project.

🧾 Key Definitions

- **Rationale** – A clear, evidence-informed explanation of *why* you are pursuing this project and *how* it will make a difference.
- **Urgency** – Why now? What is driving the need to act quickly (e.g., health disparities, new data, missed opportunities)?
- **Strategic Alignment** – How does this project support your agency's mission, Ryan White program goals, and broader public health priorities?
- **Client & Community Impact** – How will this project improve health outcomes, service access, or equity for your clients and community?

📝 Guided Prompts for Writing Your Rationale

1. **Why is it important to address this problem right now?**
    - What are the consequences of *not* acting?
    - Have there been recent changes, data trends, or community feedback pointing to the need?
2. **What impact will the project have on client outcomes or health equity?**
    - Will this project reduce a known disparity?
    - Will it improve quality of care, service access, or retention?
3. **How will your staff or agency benefit from addressing this issue?**
    - Will the project reduce workload, improve workflows, or clarify roles?
    - Will it support staff morale or capacity building?
4. **How does this work support your agency's strategic goals or Ryan White priorities?**
    - Does this connect to your agency's mission statement, performance measures, or prior CQI findings?
    - Is this part of a broader goal (e.g., Ending the HIV Epidemic, community planning, equity improvement)?

📋 Example

This project addresses persistent delays in linkage to care for newly diagnosed Hispanic/Latino clients, a disparity confirmed by quarterly performance data. If left unaddressed, this issue risks worsening health outcomes, increasing community transmission, and weakening trust in the system.

By improving coordination between testing partners and our MCM team, we expect to reduce time to linkage, boost viral suppression, and improve cultural

responsiveness. This project supports our agency's equity commitment and aligns with the TGA's priority to address disparities affecting Hispanic/Latino and transgender clients.

📌 Reflective Checkpoint Before Finalizing Your Rationale

✅ Have you clearly explained why **now** is the right time to act?
✅ Have you described how the project will improve **client outcomes or equity**?
✅ Have you highlighted any **operational or staff benefits** that build internal support?
✅ Have you tied your project to your **agency's strategy**, the Ryan White program, or local health system priorities?
✅ Does your rationale inspire action and clearly justify the project's importance?

✅ Section 5: Driver Diagram

A **Driver Diagram** is a powerful visual and strategic tool that shows *how you plan to achieve your project aim*. It links your **Aim Statement** to the **key drivers** (factors) that influence success, and to specific **Change Ideas** you will test to make improvements.

🧾 Key Definitions

- **Aim Statement** – The specific SMARTIE goal you want to achieve (from Section 3).
- **Primary Drivers** – The *major factors* that directly influence the outcome you're trying to improve.
- **Secondary Drivers** – The *specific components or sub-factors* that influence each primary driver.
- **Change Ideas** – Concrete, testable strategies you believe will move the needle on your drivers and, ultimately, your aim.

Think of your driver diagram as a roadmap for *what* you plan to influence and *how* you plan to do it.

📝 Guided Prompts for Building Your Driver Diagram

1. **Restate Your Aim**
    - Use the exact SMARTIE goal from Section 3.

2. **Identify Primary Drivers**
    - What are the big systems or processes that must work well to achieve your aim?
    - Consider categories like communication, coordination, training, client engagement, workflows, policies, or documentation.
3. **Identify Secondary Drivers**
    - What specific steps, tasks, or behaviors influence each primary driver?
    - These are smaller parts of the process that, if improved, will strengthen your primary drivers.
4. **Generate Change Ideas**
    - What actions or interventions will you test to improve your drivers?
    - Are your change ideas small, specific, and feasible to implement quickly?

📋 Example

Aim Statement:
By December 31, 2025, reduce the average time from HIV diagnosis to linkage to care for Hispanic/Latino clients from 7 days to under 3 days.

Primary Driver 1: Timely, clear communication between testing sites and case managers

- **Secondary Driver 1.1**: Real-time electronic referral system
- **Secondary Driver 1.2**: Staff training on urgent referrals
- **Change Ideas**: Use a shared referral form with timestamps; train intake staff monthly

Primary Driver 2: Availability of bilingual, culturally responsive navigation staff

- **Secondary Driver 2.1**: Recruitment and assignment of bilingual navigators
- **Secondary Driver 2.2**: Culturally relevant onboarding materials
- **Change Ideas**: Hire peer navigator from Hispanic community; develop new intake materials in Spanish

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📌 Reflective Checkpoint Before Finalizing Your Driver Diagram

✅ Does your diagram clearly connect the **aim**, **drivers**, and **change ideas**?
✅ Have you focused on factors that are **within your control** to change?
✅ Are your **primary drivers logical and actionable** based on the problem you've defined?
✅ Do your change ideas reflect **input from staff and/or clients**?
✅ Are your change ideas small enough to test in a **PDSA cycle** (Section 6)?

✅ Section 6: Plan-Do-Study-Act (PDSA) Cycle

The **PDSA Cycle** is a structured, step-by-step method for testing changes on a small scale. It allows you to implement an improvement idea, assess its impact, and adapt as needed before scaling up. This section helps you document the **entire cycle**, from initial planning through evaluation and next steps.

🧾 Key Definitions

- **Plan** – Develop your change idea and outline the details: who, what, when, where, and predicted results.
- **Do** – Carry out the plan and document exactly what happened.
- **Study** – Analyze the results and compare them to your predictions. What did you learn?
- **Act** – Decide what to do next: adopt, adapt, or abandon the change idea.

PDSA cycles are meant to be quick and iterative. Don't wait for perfection—start small, learn, and improve.

📝 Guided Prompts for Completing Your PDSA Cycle

1. **Plan**
   - What specific change will you test?
   - Who is responsible for implementation?
   - When and where will you test this change?
   - What do you predict will happen?
   - What data will you collect, and how will you measure success?

2. **Do**
   - What did you actually do? Describe the steps taken.
   - Did everything go as planned? If not, what changed?
   - Were there any surprises or barriers?
   - Document any early observations or reactions.

3. **Study**
   - What were the actual results?
   - How do they compare to your predictions?
   - What do the data or feedback show?
   - What did you learn from this test?

4. **Act**
   - Based on what you learned, what are your next steps?
     - **Adopt** (It worked — do it again or expand)

    - **Adapt** (Tweak it based on what you learned)
    - **Abandon** (It didn't work — try something else)
- Will you move to another test cycle or scale this change?

📋 Example

Plan: Test assigning a bilingual peer navigator to all newly diagnosed Hispanic/Latino clients. Prediction: 90% will link to care within 3 days. Data: date of diagnosis vs. date of first medical visit.

Do: Assigned peer navigator to 10 clients at XYZ Clinic. Tracked referral handoff times and navigator follow-up.

Study: 8 of 10 clients linked within 3 days; 2 were delayed due to transportation issues. Clients responded well to peer support.

Act: Adapt – Continue peer navigator model but integrate transportation assistance for next cycle.

📌 Reflective Checkpoint Before Finalizing Your PDSA Cycle

✅ Did you document **each step** of the cycle clearly?
✅ Are your findings supported by **data or direct observations**?
✅ Is your next step clear: adopt, adapt, or abandon?
✅ Did you keep the cycle **focused and feasible**?
✅ Are you ready to scale or test again with modifications?

✅ Section 7: Data Collection (Measurement Strategy)

Data drives your QI project forward. In this section, you'll identify which **measures** you will track to know whether your change ideas are working. You'll also establish a **baseline**, set up a **monthly tracking plan**, and clarify **who is responsible** for collecting and analyzing the data.

🧾 Key Definitions

- **Measure** – A specific metric used to monitor the impact of your QI activities (e.g., % of clients linked to care within 72 hours).
- **Aim-related Measure** – A metric that directly tracks progress toward your SMARTIE goal.

- **Driver-related Measure** – A metric that shows whether your change ideas are improving the primary or secondary drivers.
- **Baseline** – The starting value for each measure before you begin your QI interventions.
- **Tracking Period** – The months from May through December 2025 during which you'll collect and review data.

📝 Guided Prompts for Building Your Measurement Plan

1. **Identify at Least Two Measures**
   - What will you measure to track success?
     - One measure must directly relate to your **aim** (e.g., viral suppression rate, time to care).
     - The second should monitor a process or driver (e.g., % of referrals completed, # of peer navigator interactions).
2. **Define Each Measure Clearly**
   - What exactly are you counting or calculating?
   - What is the **numerator** and what is the **denominator**?
   - Will the data come from your EMR, a tracking sheet, or case manager reports?
3. **Establish Your Baseline**
   - What is the starting point before the intervention begins (as of May 2025)?
   - Use the most recent complete month of data available.
4. **Plan for Monthly Tracking**
   - How will you collect and analyze this measure monthly?
   - Who is responsible?
   - Where will the data be stored or displayed?

📋 Example

Measure 1 (Aim-related):

- % of newly diagnosed Hispanic/Latino clients linked to HIV care within 72 hours
- Baseline (May 2025): 54%
- Monthly target: increase by 3% each month through December 2025

Measure 2 (Driver-related):

- % of referrals to peer navigators made within 24 hours of diagnosis
- Baseline (May 2025): 40%
- Data source: Referral tracking log completed by testing site staff

Tracking Plan:

- Data is entered weekly by the intake coordinator, reviewed monthly by the QI lead, and discussed quarterly with the CQM committee.

📌 Reflective Checkpoint Before Finalizing Your Measurement Strategy

✅ Do your measures clearly reflect your **aim and drivers**?

✅ Are your **baselines** accurate and based on reliable data?

✅ Have you defined exactly **how** and **when** data will be collected?

✅ Is there a clear plan for **reviewing results monthly** and adjusting strategies if needed?

✅ Is **data responsibility assigned** to specific staff or roles?