Clinical Quality Management Workbook

Appendix A: Quality Improvement Project/PDSA Planning Worksheet

Subrecipient: _____

QUALITY IMPROVEMENT PROJECT STAFF:		
Type:	Name:	Email Address:
PRIMARY		
SECONDARY		
Additional		
Additional		
Additional		

PROJECT DETAILS					
PROJECT TITLE:					
PROJECT START DATE:		**PROJECT END DATE:**		**PROJECT LOCATION:**	
PROBLEM STATEMENT:					

PROBLEM STATEMENT: Describe the specific gap between the current state and desired future state of a service, process, or outcome. Use the 5Ws framework (Who, What, When, Where, and Why) to clarify the problem's scope, contributing factors, and impact on clients or staff. A strong problem statement is data-informed, actionable within the QI project timeline, and aligned with the needs of priority populations.

AIM STATEMENT:	

AIM STATEMENT: Use one to two sentences to clearly state what you will improve, by how much, by when, and for whom.
Tip: Use the SMARTIE framework — Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable — to strengthen your aim statement.

RATIONALE:	

RATIONALE: This is your chance to strengthen the "why now" *and* "why it matters" *behind your QI project. You want to guide users to connect their problem and aim to strategic priorities, health equity, and client or staff benefit — without turning it into a restatement of the problem.*
TIP: A strong rationale answers: "Why now, for whom, and to what end?" Consider using data points, client/staff stories, or recent performance reviews to reinforce the urgency and expected benefits of your improvement effort.

DRIVER DIAGRAM			
AIM: *(From Above)*	**PRIMARY DRIVERS:** **1.**	**SECONDARY DRIVERS:**	**CHANGE IDEAS** •
	2.		•
	3.		•

AIM:	PRIMARY DRIVERS:	SECONDARY DRIVERS:	CHANGE IDEAS:
By December 31, 2025, we will increase the percentage of newly enrolled Latino clients retained in Medical Case Management for at least 6 months from 62% to 80% by implementing proactive follow-up protocols, client engagement strategies, and equitable access supports. This aim supports our agency's goal of reducing racial disparities in HIV retention outcomes.	**1. Improved client follow-up and engagement practices**	**1.1 Establishment of standardized 30-day and 60-day check-ins** **1.2 Use of culturally responsive communication and follow-up methods** **1.3 Identification and resolution of client-specific engagement barriers**	• **Develop and pilot a client retention tracking dashboard for case managers** • **Implement bilingual SMS appointment reminders and check-ins using trauma-informed language** • **Assign peer navigators to new Latino clients to support engagement through shared lived experience** • **Conduct a monthly review of missed appointments and re-engagement attempts**
	2. Reduction of structural and access-related barriers to retention	**2.1 Clients experience fewer administrative burdens related to eligibility and re-certification** **2.2 Transportation and scheduling barriers are proactively addressed** **2.3 Support services are aligned with social determinants of health (e.g., housing, food security)**	• **Simplify re-certification documentation through a pre-filled renewal packet and reminders** • **Implement flexible appointment hours (e.g., evenings/weekends) to accommodate work schedules** • **Provide transportation vouchers or ride coordination for MCM appointments** • **Coordinate monthly care planning check-ins that integrate referrals for food, housing, or mental health services**
	3. Culturally responsive, trust-building client–provider relationships	**3.1 Staff demonstrate cultural humility and reduce stigma through training and practice** **3.2 Clients feel seen, heard, and supported in their lived experiences** **3.3 Communication is client-centered, strength-based, and inclusive**	• **Conduct a cultural humility and trauma-informed care training series for all MCM staff** • **Launch a client experience survey or listening session series to gather feedback from Black clients on care quality and trust** • **Develop scripts and workflows for strength-based check-ins focused on client goals, not just medical tasks** • **Pair new clients with designated case managers to support relationship-building and continuity**

PLAN, DO, STUDY, ACT CYCLE

PROJECT TITLE:	
AIM:	

AIM STATEMENT: Use one to two sentences to clearly state what you will improve, by how much, by when, and for whom.

- *Tip: Use the SMARTIE framework — Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable — to strengthen your aim statement.*

CHANGE IDEA:	

Start small and stay focused. A strong change idea is specific, testable within a short timeframe, and directly tied to one of your project drivers. Choose one clear change to test first — not an entire new process — so you can learn quickly and adapt as needed. Although it's not required, all PDSAs should be linked to a change idea from your driver diagram.

OVERVIEW NOTES:	

Describe your plan for carrying out this PDSA cycle. This should be detailed, but specifics around the different tasks should be populated as tasks in the PDSA task list.

PREDICTION:	

Outline your prediction of what will happen when you run this test. Your prediction should include what you expect to happen, and why. You may also want to describe the potential consequences of the expected outcome. When writing your prediction, if you identify an adverse outcome that you believe could/should be avoided, try adjusting the plan to reduce the chance of that negative outcome occurring.

DO: *What happened*	

Describe what happened when you ran your test and note any pertinent observations.

STUDY: *Compare to your prediction*	

Compare the results from your test to your predictions and summarize any learning.

ACT: *What next*	

Use what you learned to decide your next step: adopt, adapt, or abandon.

DATA COLLECTION				
MEASUREMENT (AIM, Primary, Secondary): **1.**	***Baseline***			
MEASUREMENT (AIM, Primary, Secondary): **2.**	***Baseline***			
MEASUREMENT (AIM, Primary, Secondary): **3.**	***Baseline***			
MEASUREMENT (AIM, Primary, Secondary): **4.**	***Baseline***			
MEASUREMENT (AIM, Primary, Secondary): 1. *Increase VL suppression on the Care Continuum Dashboard to 78%.*	***Baseline*** September 2023	***70%***	***December 2023***	***68%***
	October 2023	***77%***	***January 2024***	***71%***
	November 2023	***73%***	***February 2024***	***77%***
	Outcome		***70% to 77%***	