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Georgia Ryan White Part B

Clinical Quality Management Plan

GEORGIA DEPARTMENT OF PUBLIC HEALTH

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INTRODUCTION

About this Document

Ryan White HIV/AIDS legislation requires clinical quality management (CQM) programs as a condition of grant awards. The CQM expectations for Ryan White (RW) Part B Program recipients include: 1) Assist direct service medical providers funded through the Ryan White HIV/AIDS Treatment Extension Act in assuring that funded services adhere to established HIV clinical practice standards and Department of Health and Human Services (DHHS) Guidelines to the extent possible; 2) Ensure that strategies for improvements to quality medical care include vital health-related supportive services in achieving appropriate access and adherence with HIV medical care; and 3) Ensure that available demographic, clinical and health care utilization information is used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic.

The Georgia RW Part B Program CQM Plan is outlined in this document. This document is considered a 'living' document and revisions may be made as the Georgia Department of Public Health (DPH), Division of Medical and Clinical Program Services, Office of HIV/AIDS continues to develop and expand the RW Part B CQM Program and Plan. This Plan is effective April 1, 2023 to March 31, 2024**.** A timeline for annual implementation, revision, and evaluation of the Plan is in Appendix B of this document. Any questions regarding this plan, may be directed to the RW Part B Program CQM Team Lead, sandra.metcalf@dph.ga.gov.

Ryan White Overview

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, now the Ryan White HIV/AIDS Treatment Extension Act of 2009 is a Federal legislation that addresses the unmet health needs of people with HIV by funding primary health care and support services that enhance access to and retention in care. First enacted by Congress in 1990, it was amended and reauthorized in 1996, 2000, 2006 and 2009; it was funded at $2.49 billion in 2022.

<u>The Ryan White HIV/AIDS Treatment Modernization Extension Act of 2009</u>

Federal funds are awarded to agencies located throughout the country, which deliver care to eligible individuals under funding categories called Ryan White Parts.

- Part A funds medical and support services to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are the most severely affected by the HIV/AIDS epidemic.
- Part B provides grants for states and territories to improve the quality, availability, and organization of HIV health care and support services. Recipients include all 50 states, the District of

Columbia, Puerto Rico, the U.S. Virgin Islands, and the six U.S. Pacific territories/associated jurisdictions. In addition, Part B also includes grants for the AIDS Drug Assistance Program (ADAP).

- Part C administers funds for local community-based organizations to provide comprehensive primary health care and support services in an outpatient setting for people with HIV through Early Intervention Services program grants. Part C also funds Capacity Development grants, which help organizations more effectively deliver HIV care and services.
- Part D administers funds for local, community-based organizations to provide outpatient, ambulatory, family-centered primary and specialty medical care for women, infants, children, and youth with HIV. Part D funding may also be used to provide support services to people living with HIV and their affected family members.
- Part F funds support clinician training, technical assistance, and the development of innovative models of care to improve health outcomes and reduce HIV transmission. These programs include:
    - The Special Projects of National Significance Program, which develops, evaluates, and replicates innovative strategies and interventions for HIV care, treatment, and support to improve health outcomes for people with HIV and reduce HIV transmission.
    - The AIDS Education and Training Centers Program, which supports a network of eight regional centers (and more than 130 local affiliated sites) and two national centers to advance interprofessional training, practice transformation, and conduct HIV training for providers.
    - The Dental Programs, which provides additional funding for oral health care for people with HIV through the HIV/AIDS Dental Reimbursement Program and the Community-Based Dental Partnership Program.

HIV Care Continuum

The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the HIV Care Continuum or the HIV Treatment Cascade. The HIV Care Continuum includes the diagnosis of HIV, linkage to HIV medical care, lifelong retention in HIV medical care, appropriate prescription of antiretroviral therapy (ART), and ultimately HIV viral load suppression.

Subrecipients, also referred to as funded agencies, are encouraged to assess the outcomes of their programs along the HIV Care Continuum. Subrecipients should work with their community and public health partners to improve outcomes across the Continuum, so that individuals diagnosed with HIV are linked and engaged in care and started on ART as early as possible.

QUALITY STATEMENT

MISSION

The mission of the Ryan White Part B Clinical Quality Management Program is to ensure the highest quality of medical care and supportive services for people with HIV in Georgia.

VISION

The vision of the Clinical Quality Management Program is to ensure a seamless system of comprehensive HIV services that provide a continuum of care and eliminates health disparities across jurisdictions for people with HIV in Georgia. This will be accomplished by:

- Assessing the extent to which HIV health services provided to people with HIV under the grant are consistent with the most recent DHHS guidelines for the treatment of HIV disease and related opportunistic infections.
- Developing strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.
- Continuously implementing a statewide clinical quality management plan.
- Improving access to AIDS Drug Assistance Program (ADAP) and Health Insurance Continuation Program (HICP) services by improving application and recertification processing.
- Improving alignment across subrecipients by monitoring core performance measures across RW Part B Program subrecipients.
- Improving alignment across services through standardization of case management.
- Improving alignment across RW Programs by expanding quality related collaboration.

ORGANIZATIONAL INFRASTRUCTURE

In Georgia, the Ryan White Part B Program is administered by the Georgia Department of Public Health (DPH), Division of Medical and Clinical Program Services, Office of HIV/AIDS. The Office of HIV/AIDS funds agencies in 16 public health districts to deliver HIV/AIDS services throughout the state. These agencies are responsible for planning and prioritizing the delivery of HIV services in their respective geographic areas. All subrecipients provide primary care services. Support services are funded based on the availability of resources. The Ryan White Part B Program also funds the Georgia ADAP and HICP, which provides medication for the treatment of HIV/AIDS to eligible people with HIV or assists with health insurance premiums and co-pays.

The primary role of subrecipients is to provide medical and support services to all eligible people with HIV who reside in Georgia. Subrecipients are responsible for maintaining appropriate relationships with entities in the area they serve that constitute key points of access to the health care system for people with HIV (emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, sexually transmitted infection clinics, and others) for the purpose of facilitating early intervention for individuals newly diagnosed with HIV and individuals knowledgeable of their HIV status but not in care. Services provided must meet all service standards set forth by the state, and must align with HRSA's Ryan White Universal and Part B Programmatic and Fiscal National Monitoring Standards.

LEADERSHIP AND ACCOUNTABILITY

GEORGIA DEPARTMENT OF PUBLIC HEALTH

THE STATE OF GEORGIA THROUGH THE GEORGIA DEPARTMENT of Public Health (DPH) is the recipient of the Ryan White Part B Program grant. Georgia DPH administers the grant through the Division of Medical and Clinical Program Services, Office of HIV/AIDS.

OFFICE OF HIV/AIDS

The Office of HIV/AIDS provides oversight and management of the RW Part B Program grant. The Office of HIV/AIDS Director provides leadership and coordination of HIV care and prevention activities. The Office of HIV/AIDS leadership is dedicated to the quality improvement process and guides the CQM Plan. The HIV Care Manager is responsible for ensuring administration of the grant, including the development and implementation of the CQM Plan.

OTHER DPH SECTIONS

HIV/AIDS Surveillance: The Office of HIV/AIDS continues to work with the HIV/AIDS Epidemiology Unit to utilize HIV and AIDS case reporting data for planning and quality improvement opportunities.

RYAN WHITE PART B PROGRAM SUBRECIPIENTS

RW Part B subrecipients are responsible for ensuring clinical quality management components of Grant-in-Aid (GIA) and contractual agreements are met. The FY2023-2024 CQM deliverables include the following

language, as referenced in the Georgia RW Part B/ADAP/HICP Policies and Procedures: Subrecipients are expected to refer to the Georgia Ryan White Part B CQM Plan which contains goals, objectives, and strategies to ensure implementation and monitoring of CQM activities, as well as compliance with HRSA's CQM expectations at both state and local levels. Ryan White Part B CQM Program activities are delineated in the plan, including capacity building, and providing quality-related technical assistance to subrecipients. The Ryan White Part B CQM Core Team provides oversight and facilitation of the plan and is composed of multidisciplinary professionals within the Office of HIV/AIDS. In addition, the statewide Ryan White Part B CQM Core Team Committee includes representation from all subrecipients, additional Office of HIV/AIDS staff, Ryan White Parts A, C, D, F, and consumers.

Subrecipients are expected to comply with the following requirements:

- Ensure that the medical management of HIV infection is in accordance with the United States Department of Health and Human Services (DHHS) HIV-related guidelines. Compliance with DHHS HIV-related guidelines is a requirement of the Health Resources and Service Administration (HRSA) for sites receiving Ryan White HIV/AIDS Treatment Extension Act funding. The DHHS guidelines are considered 'living' documents and are available at CLINICAL INFO HIV.gov, https://clinicalinfo.hiv.gov/en/guidelines.
- Ensure compliance with the Georgia Department of Public Health (DPH), Office of HIV/AIDS, Ryan White Part B Clinic Personnel Guidelines (current edition).
- Ensure that registered professional nurses (RNs), advanced practice registered nurses (APRNs), and physician assistants (PAs) practice under current HIV/AIDS-related nurse and PA protocols. The recommended protocols and/or resources include the following as applicable:
    - Georgia Department of Public Health, Office of Nursing, Standard Nurse Protocols for Registered Professional Nurses in Public Health, Adult with HIV (current edition).
    - Georgia Department of Public Health Policy #PT-18001, Georgia AIDS Drug Assistance Program Advanced Practice Registered Nurse Provider Status Policy and Procedure (current edition).
    - Georgia Department of Public Health Policy #PT-18002, Georgia AIDS Drug Assistance Program Physician Assistant Provider Status Policy and Procedure (current edition).
- Ensure that all physicians, pharmacists, and all other licensed medical professionals possess current licensure and/or certification.
- Ensure that all physicians are practicing under current HIV/AIDS-related protocols and are practicing under the current laws of the state of Georgia. If there is any lapse in licensure and/or the occurrence of suspension that deems a medical professional unable to practice medicine under current laws, the Office of HIV/AIDS's District Liaison is to be notified immediately.
- Develop and implement a CQM Program according to HRSA's HIV/AIDS Bureau (HAB) expectations for Ryan White recipients, to include the following:
    - A leader and team to oversee the CQM Program
    - CQM goals, objectives, and strategies
    - A written CQM Plan, updated annually and Work Plan, updated quarterly
    - Continuous Quality Improvement (CQI) projects that incorporate Quality Improvement (QI) methodologies to address performance measures below state goals, updated quarterly
    - Performance measures and mechanisms to collect data
    - Communication of results to all levels of the organization, including consumers as appropriate.
- Participate in the statewide Ryan White Part B CQM Program, including but not limited to a designated representative and attendance in CQM Core Team Committee meetings.
- Ensure timely **and accurate** data entry in CAREWare as indicated for Part B CQM activities.
- Monitor performance measures as determined by the Georgia Ryan White Part B CQM Program.

- Participate in HIV clinical and case management chart reviews conducted by state office CQM staff.
- Provide CQM Plans, reports, including CQI activities, client satisfaction survey summary results, improvement plans, and other information related to the subrecipient CQM Program, as requested by the Office of HIV/AIDS Ryan White Part B District Liaison and/or CQM staff. Allow the District Liaison and/or CQM staff access to all CQM information and documentation.
- Ensure compliance with the Georgia Ryan White Part B Case Management Standard Operating Procedures (current edition).

CLINICAL QUALITY MANAGEMENT COMMITTEES

CLINICAL QUALITY MANAGEMENT CORE TEAM

Purpose

- To provide oversight and facilitation of the Georgia RW Part B CQM Plan.
- To provide a mechanism for the objective review, evaluation, and continuing improvement of HIV care and support services.

Membership

- Core Team membership will be reviewed annually, and changes made accordingly.
- Each RW Part B Program subrecipient must identify one primary representative and an alternate to represent their agency. The primary representative is an active member of the CQM Core Team, and the alternate will be available to serve on the team if the team member cannot attend (see Appendix C for committee members).
- Membership by Consumer Representatives, also referred to as Peer Representatives, is voluntary. The CQM Core Team aims to have four to five gender diverse Consumer Representatives from different regions of Georgia. The Consumer Representative does not represent a particular district, but rather represents consumers who have access to RW Part B Program services. Consumers Representatives are selected as needed following submission of interest from candidates.

The Core Team will include the following members:

Senior Office of HIV/AIDS Leadership:

All the positions below, or their designees, may attend meetings to represent the involvement of senior leadership.

Office of HIV/AIDS Staff:

- Office of HIV/AIDS Director – duties include:
    - Office of HIV/AIDS leadership
    - Coordination of HIV care and prevention activities
- HIV Care Program Manager – duties include:
    - Grant oversight and management, including allocation of resources
    - Ensuring development/implementation of the CQM Plan and CQI projects.

- Assistant HIV Care Program Manager – duties include:
    - Assists with grant oversight and management
    - Supervises District Liaisons
    - Ensures development/implementation of programmatic monitoring policies, tools, and activities
- HIV Care District Liaisons – duties include:
    - Closely monitor the programmatic and fiscal requirements of all contracts and Annex-GIA awards including CQM requirements
    - Ensure CQM/CQI findings and reports are shared at the local level
    - Participate in systems-level CQI projects
    - Monitor general programmatic performance measures
    - Ensure complete implementation of National Monitoring Standards (NMS) at the state and local levels
- HIV Care Financial District Liaison – duties include:
    - Assists with budget, contract, financial/performance related records monitoring and accounting procedures
    - Monitors, assesses, and evaluates program to determine compliance with state and/or federal fiscal guidelines
    - Provides technical assistance
    - Reviews and interprets fiscal regulations related to the program
- Quality Management Nurse Consultant Team Lead - duties include:
    - Supervise Quality Management (QM) Nurse Consultants
    - Coordinate day-to-day CQM Program operations and meetings
    - Coordinate systems-level CQI projects
    - Ensure development, implementation, and evaluation, of the CQM Plan and Work Plan
    - Ensure revision of the CQM Plan at least annually, and the Work Plan at least quarterly
    - Oversee the submission of required reports related to CQM to upper management
    - Coordinate and ensure CQM/CQI and other HIV-related training is available
    - Closely monitor assigned subrecipients' CQM Plans and quarterly reports
    - Monitor performance measure indicators and oversee technical assistance provision to RW Part B Program subrecipients
    - Oversee technical assistance provision to RW Part B Program subrecipients (i.e., development of local CQM Plans, CQI projects, and nursing/clinical services)
    - Coordinate site visits to review HIV care clinical performance indicators
    - Coordinate and lead CQM Core Team meetings
    - Participate in **development of HIV Program Standards and Training for the GA DPH Office of Nursing Policy and Procedure Manual for Public Health Nurse Training**
    - Participate in Georgia Ryan White Programs quality-related committees and activities
    - Coordinate review and revision of HIV care nurse protocols
    - Develop and revise HIV-related clinical guidelines and other guidelines/polices as indicated
    - Participate in Metro Atlanta EMA Part A and Part D Quality Management Committee meetings
    - Attend educational conferences or other events sponsored by HRSA, DPH, AIDS Education Training Centers, professional organizations, or other appropriate sponsoring organizations to maintain current knowledge of HIV care and Clinical Quality Management
- Quality Management Nurse Consultant - duties include:
    - Assist with coordination of day-to-day operations of the CQM Program:
    - Plan meetings and/or conference calls
    - Communicate with the Core Team and subcommittees

    - Complete reports and other assignments
    - Participate in systems-level CQI projects
    - Participate on the CQM Core Team
    - Closely monitor assigned subrecipients' CQM Plans and quarterly reports
    - Provide technical assistance to RW Part B Program subrecipients in the development of local CQM Plans and activities
    - Participate in site visits to review HIV care clinical performance indicators
    - Coordinate or participate in review and revision of HIV care nurse protocols
    - Participate in **development of HIV Program Standards and Training for the GA DPH Office of Nursing Policy and Procedure Manual for Public Health Nurse Training**
    - Assist in development or revision of HIV-related clinical guidelines, polices, and/or procedures
    - Participate in Metro Atlanta EMA Part A and Part D Quality Management Committee meetings
    - Attend educational conferences or other events sponsored by HRSA, DPH, Georgia AETC (GA AETC), professional organizations, or other appropriate sponsoring organizations to maintain current knowledge of HIV care and Clinical Quality Management
- Ryan White Part B Quality Clinical Case Manager(s) - duties include:
    - Assist with coordination of day-to-day operations of the CQM Program:
    - Plan meetings and/or conference calls
    - Communicate with the Core Team and subcommittees
    - Complete reports and other assignments
    - Participate in systems-level CQI projects
    - Participate on the CQM Core Team
    - Ensure development, implementation, and evaluation of statewide case management Standard Operating Procedures (SOPs) and tools
    - Ensure CQM/CQI and case management training is available
    - Assist with revision of the CQM Plan and Work Plan
    - Closely monitor assigned subrecipients' CQM Plans and quarterly reports
    - Provide technical assistance to RW Part B Program subrecipients in the development of local CQM Plans and **Quality Improvement projects**
    - Conduct site visits to review case management services
    - Monitor utilization of ADAP and HICP, assist with HICP trainings, provide quality tools to improve efficacy of ADAP and HICP **utilization across Georgia**, **and assist with increasing HICP program enrollment**
    - Participate in Georgia Ryan White Programs quality-related committees and activities
    - Attend Metro Atlanta EMA Planning Council, Part A and Part D Quality Management Committee meetings
    - Attend educational conferences or other events sponsored by HRSA, DPH, GA AETC, professional organizations, or other appropriate sponsoring organizations to maintain current knowledge of HIV case management and Clinical Quality Management
- Medical Consultant – HIV Office – duties include:
    - Participate on the CQM Core Team
    - Provide medical expertise and technical assistance to the Office of HIV/AIDS, ADAP, RW Part B Program subrecipients and others
    - Participate in the Formulary and Therapeutics Committee.
    - Conduct site visits to review clinical performance measures including management and utilization of antiretroviral therapy
    - Revise and approve HIV nurse protocols

    - Provide training to HIV providers and others as indicated
    - Mentor physicians inexperienced in HIV care
    - Assist with CQM-related reports and assignments
    - Assist with development and/or revisions of medical guidelines, polices, and/or procedures
- AIDS Drug Assistance Program (ADAP)/Health Insurance Continuation Program (HICP) Manager – duties include:
    - Manage and coordinate ADAP/HICP, Hepatitis C Program and all related components of the CQM Plan including CQI projects and performance measures
    - Provide ADAP/HICP related technical assistance to support CQI project goals and performance
    - Facilitate ADAP/HICP trainings
    - Facilitate Georgia ADAP/HICP CQM Subcommittee
    - Ensure CQM/CQI findings/reports are shared regarding systems-level CQI projects
    - Attend educational conferences or other events sponsored by HRSA, DPH, GA AETC, professional organizations, or other appropriate sponsoring organizations to maintain current knowledge of HIV clinical practice and/or clinical quality management
- ADAP Pharmacy Director – duties include:
    - Supervise the ADAP Business Operations Specialist
    - Provide HIV and Hepatitis C medication management training and educational resources for the ADAP Contract Pharmacy (ACP) Network
    - Oversight and monitoring of daily ADAP pharmacy operations for the ACP Network
    - Oversight and monitoring of ADAP contract pharmacy on-site audits and visits to review contract compliance including antiretroviral therapy management and dispensing
    - Pharmaceutical-related system improvements of ADAP and the ACP Network
    - Provide pharmacy expertise and TA to the Office of HIV/AIDS, ADAP, Part B subrecipients and others
    - Participate on the **Georgia ADAP Formulary and Clinical Therapeutics Committee (FCTC)**
    - Participate in the revision of HIV nurse protocols
    - **Participate on the DPH Viral Hepatitis Elimination Workgroup**
    - Ensure CQM/CQI findings/reports are shared regarding systems-level CQI projects
    - Develop and revise HIV-related medication guidelines and other guidelines/polices as indicated
    - Attend educational conferences or other events sponsored by HRSA, DPH, GA AETC, professional organizations, or other appropriate sponsoring organizations to maintain current knowledge of HIV clinical practice and/or clinical quality management
- Ryan White Database Manager – duties include:
    - Maintain CAREWare database
    - Provide TA and training to state and subrecipient staff
    - Create custom reports to collect performance measure data.
    - Generate CAREWare reports
    - Delegate duties to CAREWare staff as needed

<u>Other CQM Core Team Members:</u>

- Consumer Representatives - duties include:
    - Provide a critical consumer perspective
    - Participate in CQM Core Team meetings
    - Participate in CQM Core Team CQI projects

    - Provide direct feedback on:
        - Quality of services
        - Services needed and how to improve service delivery models
        - Identification of service barriers and suggestions to overcome barriers
        - Organizational assessments
- Representative from HIV/AIDS Surveillance (Ad hoc) – duties include:
    - Provide HIV and AIDS case reporting data for planning and quality improvement opportunities as needed
- RW Part B Program Subrecipients - HIV/QM Coordinator – duties include:
    - Agency/program representative
    - Ensure representation and participation in CQM Core Team Committee
    - Ensure that subrecipient CQM Plan is updated annually, and activities align with Georgia RW Part B CQM Plan
    - Ensure completion and submission of Georgia RW Part B CQM Quarterly Report
    - Participate with state CQM staff in CQM activities, providing feedback and suggestions
- Representatives from RW Program Parts A, C, and D – duties include:
    - Represent their agencies/programs
    - Promote alignment across RW Programs statewide
- Medicaid Representative (Ad hoc) – duties include:
    - Assist with Medicaid-related CQM activities as needed
- Representative from HIV Prevention – duties include:
    - Provide updates on HIV Prevention activities
    - Coordinate activities across programs as possible
- Representative from HIV Perinatal Program – duties include:
    - Provide updates on program implementation
    - Share aggregate data as indicated
- All other RW Part B Program Office of HIV/AIDS staff –duties include:
    - Participate in activities of the CQM Program/Plan as needed (see Appendix C for 2023-2024 Core Team Members)

<u>Communication</u>

- The Core Team meets at least once quarterly. Meetings are through internet-based meeting platforms and/or in-person.
- Additional conference calls and electronic communication is ongoing, as needed.
- The Core Team shares CQM/CQI findings/reports within DPH; with the Office of HIV/AIDS, RW Part B Program subrecipients, and others.

<u>General Core Team Responsibilities</u>

- The Quality Management Nurse Consultant Team Lead serves as the key contact and team leader for the CQM Program.
- At least one member of the CQM Core Team routinely attends the Metro Atlanta EMA Planning Council, Part A and Part D Quality Management Committee meetings.
- The Core Team is responsible for guiding the overall CQM Program including determining priorities, setting goals, creating/revising the Work Plan (see Appendix A), preparing reports, and evaluating the program and plan.
- The Core Team:
    - Determines the need for subcommittees and guides the subcommittee's Work Plan
    - Actively participates in meetings, conference calls, and other activities as needed

- Determines performance measures, and identifies indicators to assess and improve performance
- Shares findings with the Office of HIV/AIDS, RW Part B Program subrecipients, DPH leadership and others
- Reviews and updates the CQM Plan annually
- Makes recommendations to the Office of HIV/AIDS for appropriate education related to CQI topics
- Conducts evaluation activities

SUBCOMMITTEES

Subcommittees are created by the Core Team and are ad-hoc. Subcommittees when active, meet at least quarterly.

Georgia ADAP/HICP Clinical Quality Management Subcommittee

- Goal: To improve access to ADAP and HICP services.
- Membership: A diverse mix of Office of HIV/AIDS staff, medical and pharmacy experts, case managers, and consumers. Members will be determined as needed if the committee needs to be called into session (see Appendix C for committee members).
- Responsibilities:
  - Comply with the Core Team's overall goals and Work Plan
  - Actively communicate with the CQM Core Team
  - Submit meeting minutes to CQM Core Team
  - Monitor ADAP/HICP policy, processes, and progress with a quality management perspective
  - Identify ADAP/HICP problems/issues and make recommendations for improvement

OFFICE OF HIV/AIDS – HIV CARE TEAM

- Goal: To improve HIV care systems through planning, implementation, monitoring, and evaluation of clinical quality management and improvement projects.
- The HIV Care Team includes: the HIV QM Nurse Consultant Team Lead, HIV QM Nurse Consultants, RW Part B Clinical Quality Case Managers, HIV Care Manager, ADAP/HICP Manager, ADAP Pharmacy Director, HIV Medical Consultant, ADAP and HICP staff, District Liaisons, RW Database Manager, QM Data Analyst, and staff.
- Responsibilities:
  - Develop, implement, monitor, and evaluate the CQM Plan
  - Identify areas for CQI projects
  - Conduct and evaluate CQI projects
  - Document CQI projects and results
  - Utilize CQI methodologies such as the Model for Improvement- Plan, Do, Study, Act (PDSA)
  - Report back to CQM Core Team as appropriate
  - Systematize changes if appropriate

LOCAL SUBRECIPIENTS AND CQM COMMITTEES

- Each subrecipient is required to convene and maintain a local HIV-specific CQM committee.
- This committee should contain representation of key stakeholders including an identified committee chair, a medical provider, nurses, case managers, clerks, consumers, and other relevant persons.

- Local CQM committees should meet at least quarterly, and guide HIV care related CQM activities.
- The local CQM committee is responsible for developing, implementing, monitoring, and evaluating the local CQM Plan.

COORDINATION WITH OTHER STATEWIDE QI/QA ACTIVITIES

COORDINATION ACROSS RYAN WHITE PROGRAMS

- The RW Part B Program CQM Plan focuses on collaboration of quality activities across all RW Parts in Georgia.
- The RW Part B CQM Core Team involves participation of members from RW Parts A, C, D and F.
- A CQM staff person attends the Metro Atlanta EMA and Part D QM Committee meetings. The CQM Core Team collaborates across RW Programs on CQM activities, when possible.

COORDINATION WITHIN DPH

- HIV QM Nurse Consultants **participate in development of HIV Program Standards and Training for the GA DPH Office of Nursing Policy and Procedure Manual for Public Health Nurse Training**.
- The Core Team includes an ad hoc member of the HIV/AIDS Surveillance Unit.
- The Core Team includes HIV Prevention and HIV Perinatal Coordinator representatives. The Core Team collaborates on strategies to reduce perinatal HIV transmission in Georgia.
- A Core Team member participates on the Georgia Oral Health Coalition as available.
- The Core Team collaborates with other sections and shares quality findings within DPH as indicated.

COORDINATION WITH ADAP/HICP

- The overall RW Part B Program CQM Plan includes goals specific to ADAP/HICP. The ADAP/HICP Manager, ADAP/HICP Assistant Manager, HIV Medical Consultant and ADAP Pharmacy Director are members of the CQM Core Team.
- The Georgia ADAP/HICP CQM Subcommittee meets as needed and reports to the CQM Core Team.

FEEDBACK FROM KEY STAKEHOLDERS

- The Core Team communicates findings and solicits feedback from both internal and external key stakeholders, i.e., Office of HIV/AIDS staff, Georgia DPH programs, Georgia Ryan White Parts A, C, D and F program representatives, Georgia Ryan White Part B subrecipients, and consumers on an ongoing basis.
- Written reports are shared with key stakeholders.
- Stakeholders are given the opportunity to provide feedback to reports and to prioritize quality activities.
- The Office of HIV/AIDS maintains current Part B CQM Plans, reports, and other related information on the Office's web pages.
- Georgia's 2022-2026 HIV Prevention and Care Plan which includes the Statewide Coordinated Statement of Need, reflects the shared vision and values regarding how best to deliver HIV prevention and care services through three political jurisdictions and their respective planning bodies.

CAPACITY BUILDING

- Ryan White Part B Program CQM staff participate in Center for Quality Improvement and Innovation (CQII) trainings and webinars to support their ongoing CQM skills development. This enables staff to provide and coordinate technical assistance/training for RW Part B Program subrecipients. In addition, subrecipients and the CQM Core Team are informed of CQII trainings and webinars.
- CQII training materials and resources are utilized as much as possible.
- CQM technical assistance/training needs are assessed through requests in subrecipients' applications, monitoring of local CQM Plans, programs, quarterly reports and through training evaluations and/or needs assessments.
- Subrecipients are selected to showcase best practices and/or success with improvement projects.
- The network of RW Part B providers are encouraged to complete ongoing HIV care training through sources such as DHHS, HIV.gov, HRSA/HAB, AIDS Education Training Centers, National HIV Curriculum, and to obtain professional HIV certifications, i.e., AAHIVS, ACRN.
- The HIV Medical Consultant provides training and serves as a medical consultant as needed.

EVALUATION

SELF-ASSESSMENT/CQM PLAN EVALUATION

- The CQM Core Team completes the *Organizational Assessment Tool for Ryan White HIV/AIDS Program-funded Part B Recipients* at least annually.
- The CQM Core Team completes an annual assessment and subsequent revision of the CQM Plan.

EVALUATION OF SUBRECIPIENT CQM PLANS

- CQM staff members annually or quarterly review as applies, subrecipient CQM Plans, Work Plans, CQI activities, progress on Case Management Standard Operating Procedures (SOPs) and performance indicators. The state CQM staff provides feedback and technical assistance, as indicated to subrecipients.

EXTERNAL EVALUATION

- CQM Plans and progress are reported to HRSA during Part B grant applications and progress reports. HRSA provides external feedback regarding the Georgia RW Part B Program CQM Program.

DPH EVALUATION

- At least annually finding are reported to leadership within DPH.
- A revised CQM Plan is submitted to Office of HIV/AIDS leadership for approval on an annual basis.

RESOURCES

- Human Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program https://ryanwhite.hrsa.gov/
- Center for Quality Improvement and Innovation (CQII) - https://careacttarget.org/cqii
- DHHS HIV-related Guidelines - https://clinicalinfo.hiv.gov/en/guidelines.
- Metro Atlanta EMA Ryan White Part A Quality Management Committee - http://www.ryanwhiteatl.org/
- AIDS Education and Training Center Programs - https://aidsetc.org/
- Georgia AIDS Education and Training Center (Georgia AETC) - https://www.seaetc.com/state-partner-information/georgia-aetc/
- HIV/AIDS Epidemiology Unit - https://dph.georgia.gov/georgias-hivaids-epidemiology-section
- Georgia Ryan White Part B Service Standards https://dph.georgia.gov/hiv-care/care-services
- Atlanta Family Circle Ryan White Part D QM Committee
- Georgia DPH Programs https://dph.georgia.gov/about-dph
- National HIV/AIDS Strategy (2022-2025) https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025
- National HIV Curriculum - https://www.hiv.uw.edu/
- TargetHIV - https://targethiv.org/
- HIV.gov - https://www.hiv.gov/

PERFORMANCE MEASUREMENT SYSTEM

The Georgia Department of Public Health, Office of HIV/AIDS administers statewide HIV Prevention and Care Programs. The Georgia Ryan White Part B Program leads a comprehensive system of HIV care and treatment, in alignment with the four National HIV/AIDS Strategy goals:

- Prevent new HIV infections
- Improve HIV-related health outcomes of people with HIV
- Reduce HIV-related disparities and health inequities, and
- Achieve integrated and coordinated efforts that address the HIV epidemic among all partners and stakeholders

The Georgia Ryan White Part B Program acknowledges the importance of HIV/AIDS Bureau (HAB) core performance measures as key indicators of progress towards National HIV/AIDS Strategy goals. The Clinical Quality Management Core Team establishes annual core performance measure goals and collaborates on steps to measure and accomplish these goals. The table below depicts fiscal year 2023-2024 goals for HAB Core Performance Measures, definitions, and previous years outcomes. Further details on data collection are in the sections to follow.

GEORGIA RYAN WHITE PART B PROGRAM

CORE PERFORMANCE MEASURES	FY2023-2024 GOALS	OUTCOMES		
		DEC 2020	DEC 2021	DEC 2022
HIV Viral Load Suppression	90% of people with HIV will have a HIV viral load (VL) less than 200 copies/mL at last HIV VL test during the measurement year.	86%	88%	87%
	Numerator: Number of people in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. Denominator: Number of people with HIV[2], who had at least one Outpatient Ambulatory Health Service (OAHS) visit in the measurement year.			
Prescription of HIV Antiretroviral Therapy	97%[3] of people with HIV were prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year.	98%	97%	98%
	Numerator: Number of people in the denominator prescribed HIV antiretroviral therapy during the measurement year. Denominator: Number of people with HIV[2] who had at least one OAHS visit in the measurement year.			
HIV Medical Visit Frequency	85%[1] of people with HIV had at least one HIV medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between HIV medical visits.	76%	77%	77%
	Numerator: Number of people in the denominator who had at least one OAHS visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first OAHS visit in the prior 6-month period and the last OAHS visit in the subsequent 6-month period. Denominator: Number of people with HIV[2] who had at least one OAHS visit in the first 6 months of the 24-month measurement period.			

GEORGIA RYAN WHITE PART B PROGRAM

CORE PERFORMANCE MEASURES	FY2023-2024 GOALS	OUTCOMES		
		DEC 2020	DEC 2021	DEC 2022
Gap in HIV Medical Visits	Percent of people with HIV who did not have a HIV medical visit in the last 6 months of the measurement year will be 10%[4] or less.	8%	10%	11%
	Numerator: Number of people in the denominator who did not have an OAHS visit in the last 6 months of the measurement year. Denominator: Number of people with HIV[2] who had at least one OAHS visit in the first 6 months of the measurement year.			
Pneumocystis jiroveci Pneumonia (PCP) Prophylaxis	85%[5] of people with HIV with a CD4 count below 200 cells/mm^3 during the measurement year were prescribed PCP prophylaxis.	89%	85%	84%
	Numerator: Number of people in the denominator who were prescribed PCP prophylaxis within the measurement year. Denominator: Number of people with HIV[2] who had at least one OAHS visit in the measurement year with a CD4 count below 200 cells/mm^3.			
Annual Retention in Care	Percent[6] of people with HIV who had at least two encounters within the 12-month measurement year.	91%	92%	91%
	Numerator: Number of people in the denominator who had at least two HIV medical care encounters at least 90 days apart within a 12-month measurement year. At least one of the two HIV medical care encounters need to be a medical visit with a provider with prescribing privileges. Denominator: Number of people with HIV[2] who had at least one HIV medical encounter within the 12-month measurement year. An HIV medical care encounter is a medical visit with a provider with prescribing privileges or an HIV viral load test.			

[1]Change from FY2019-2020 goal of 68%
[2]Changed to "currently active" FY2020-2021
[3]Changed from FY2021-2022 goal of 95%
[4]Change from FY2019-2020 goal of 15% or less
[5]Change from FY2020-2021goal of 95%
[6]Goal to be determined

DATA COLLECTION

DATA COLLECTION STRATEGIES

- The HIV Data Team, HIV/AIDS Surveillance Unit, and others assist with data collection strategies.
- Data Sources include the following:
  - CAREWare
  - RW Data Reports
  - Clinical Chart Review Tool
  - Programmatic monitoring tools
  - Reports from subrecipients
  - Pharmacy Benefits Manager (PBM) database
  - Client satisfaction surveys
  - Case Management Chart Review Tool
  - Clinic/district specific surveys
  - HIVQM Module
- Data collection when applicable is based on appropriate sampling methodologies.

REPORTING MECHANISMS

- Ryan White Part B Program subrecipients are required to report data on key performance indicators.
- CQM staff review data and compile findings.
- CQM staff review subrecipient CQM Plans and reports for effectiveness and accuracy.
- Findings are shared with RW Part B CQM Core Team, HIV providers, RW Part B Program subrecipients, the Office of HIV/AIDS, DPH leadership, and others.
- Findings are used to guide CQI activities.

PERFORMANCE MEASUREMENT

Key clinical and non-clinical performance indicators are measured statewide (see Appendices D and E). HRSA/HAB HIV performance measures, including all core measures are integrated into review tools and CAREWare.

- HRSA/HAB performance measures are available in CAREWare. The CAREWare performance measure portfolio is revised and updated as needed.
- RW Data Manager and Quality Program Analyst produce quarterly HAB Reports from CAREWare data, which comprise all core measures and additional performance measures.
- Performance measures are integrated into the Clinical and Case Management Chart Reviews.

- Part B subrecipient reports include performance measures from the Part B Implementation Plan.
- HIV QM Nurse Consultants and Medical Consultant review RW Part B Program HIV clinical charts for key clinical performance measures.
- RW Part B Clinical Quality Case Managers review case management charts for compliance with case management standard operating procedures.
- District Liaisons monitor selected general RW programmatic measures.
- ADAP/HICP staff review ADAP and HICP performance measures through data reports.
- Performance measures monitored by the Georgia Ryan White Part B Program are also used by subrecipients to assess the efficacy of programs and to analyze and improve gaps in the HIV Care Continuum.

PERFORMANCE MEASUREMENT EVALUATION

- Data is used to identify gaps in care and service delivery.
- Evaluation of CQI projects is ongoing. The Work Plan is updated at least quarterly.
- The Part B CAREWare database is utilized whenever possible to collect data for statewide performance measures.
- RW Part B Program subrecipients monitor selected performance measures and report to the Program. The Core Team reviews these measures and compiles reports.
- RW Part B Program subrecipients and general RW Program performance measures are monitored by the District Liaisons for compliance with the Annex-GIA and/or contract award deliverables (see Appendix E Monitoring Table).
- HIV QM Nurse Consultants, RW Part B Clinical Quality Case Managers, and the Medical Consultant review RW Part B subrecipient clinical and case management charts for performance measures (see Appendices D and E). Findings are summarized and reported back to each site with a request for improvement plan based on findings.
- RW Part B Quality Clinical Case Managers monitor Ryan White Part B subrecipients for compliance with case management SOPs and performance measures.
- The CQM Core Team assesses the CQM Program for effectiveness, at least annually.

CLINICAL QUALITY MANAGEMENT

CLINICAL QUALITY MANAGEMENT WORK PLAN

- The Clinical Quality Management Plan includes a 'living' Work Plan that is updated at least quarterly.
- The Work Plan specifies objectives and strategies for CQM Plan goals listed below in Clinical Quality Management and further detailed in the Clinical Work Plan included in Appendix A.

CLINICAL QUALITY MANAGEMENT 2023-2024 GOALS AND OBJECTIVES

GOAL 1:

CONTINUOUSLY IMPLEMENT A STATEWIDE RYAN WHITE PART B CLINICAL QUALITY MANAGEMENT PLAN, THAT IS UPDATED AT LEAST ANNUALLY

Objectives include:

1a. Provide quality improvement (QI)/quality management (QM) training based on identified needs.

1b. Assure that subrecipients conduct at least one quality improvement project each the year, to include any core measures that are below state goals.

1c. Communicate findings to key stakeholders at least biannually.

1d. Update the CQM Plan at least annually and the CQM Work Plan at least quarterly.

1e. Require that all RW Part B Program subrecipients revise written CQM Plans annually, Work Plans quarterly, and submit quarterly CQM progress reports to include Continuous Quality Improvement (CQI) project updates.

GOAL 2:

IMPROVE EFFICIENCY OF THE GEORGIA AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Objectives include:

2.a. Monitor viral load suppression among people with HIV **enrolled in ADAP to** maintain viral load suppression at **75**% or greater.
2.b. Monitor the percentage of new ADAP applications that were determined to be approved in the measurement quarter at 90% or greater.
2.c. Monitor the percentage of ADAP annual recertifications that were determined to be approved in the measurement quarter at 90% or greater.
2.d. Conduct an internal audit of up to 5% of ADAP application forms.
2.e. Monitor **medication** compliance and adherence to antiretroviral regimens through the **third-party administration** system.
2.f. Systematically review ADAP **clinical and claims data** to identify inappropriate antiretroviral therapy (ART) regimens or components.

GOAL 3:

IMPROVE EFFICIENCY OF THE GEORGIA HEALTH INSURANCE CONTINUATION PROGRAM (HICP)

Objectives include:

3.a. Monitor viral load suppression among people with HIV **enrolled in HICP to maintain** viral load suppression at 85% or greater.
3.b. Monitor the percentage of new HICP applications that were determined approved in the measurement quarter at 90% or greater.
3.c. Monitor the percentage of HICP annual recertifications that were determined to be approved in the measurement quarter at 90% or greater.
3.d. Conduct an annual audit of HICP applications and/or recertifications.

GOAL 4:

IMPROVE THE QUALITY OF HEALTH CARE AND SUPPORTIVE SERVICES

Objectives include:

4.a. Monitor performance measures, including stratified core measures in all subrecipients.
4.b. Continue CQI project to improve core measures for HIV Medical Visit Frequency and Gap in HIV Medical Visits to attain state goals of 85% and 10% respectively.
4.c. Continually monitor the Acuity Scale and Self-Management Model.
4.d. Implement the *Georgia HIV/AIDS Case Management Standard Operating Procedures*.
4.e. Participate in quality-related activities across Ryan White Programs (Parts A, B, C, and D) in Georgia.

4.f. The percent of pregnant **clients** with HIV prescribed antiretroviral therapy will be 95% or greater.
4.g. Monitor, assess and improve perinatal systems of care for **clients** with HIV and their infants.
4.h. Continue CQI Project to improve the statewide Viral Load Suppression rate and attain state goal of 90%.
4.i. Monitor measures to verify compliance with HRSA regulations related to 'vigorous pursuit' and payer of last resort.
4.j. Monitor compliance with RW Part B and Emerging Communities (EC) program requirements.

CLINICAL QUALITY MANAGEMENT TIMELINE

- The CQM Plan includes a timeline to ensure annual revision of the CQM Plan.
- The timeline incorporates development, implementation, and revision of the plan based on the Ryan White Part B Program grant year.
- The timeline includes quarterly CQM Core Team meetings, review, and updates to the CQM Plan and Work Plan (see Appendix B).

CLINICAL QUALITY MANAGEMENT PROGRAM PERFORMANCE MEASURES

- Performance measures for the upcoming project period for each funded service category are included in Appendices D and E.

CONTINUOUS QUALITY IMPROVEMENT

- The CQM Core Team and/or the Office of HIV/AIDS Care Team select and prioritize statewide or system CQI projects.
- Performance measure data is utilized to guide project selection.
- The CQI Methodology utilized is Model for Improvement - Plan-Do-Study-Act (PDSA) (see Appendix F)
- Improvement projects are documented in the CQM Work Plan.
- Subrecipients develop CQI projects for performance measures not achieving HAB Report state goals.
- Subrecipients report progress on CQI projects quarterly.

CONTINUOUS QUALITY IMPROVEMENT PROJECTS AND GOALS

CQI projects are selected to align with overarching National HIV/AIDS Strategy, Georgia RW Part B Program outcomes on HAB Performance Measures and HRSA recommendations. CQI projects are detailed in the CQM Work Plan (see Appendix A). The Work Plan is revised at least quarterly by members of the Core Team. The Work Plan includes goals, objectives, strategies, assignments, timeline, and progress for performance goals and outcome measures.

- The CQM Plan includes a 'living' Work Plan (Appendix A) that is updated at least quarterly.
- The Work Plan specifies objectives and strategies for CQM Plan goals. The following statewide clinical CQI projects are included in this plan and the Work Plan.
- Improve rates for HIV Medical Visit Frequency and Gap in HIV Medical Visits to reach state goals of 85% and 10% respectively.
    - Use CAREWare data to assess, measure rates and monitor trends
    - Review processes for CAREWare data entry, ensure data integrity and provide technical assistance, as needed
    - Encourage subrecipients to produce 'patient drill down' lists from CAREWare as tool for evaluation, to identify barriers and develop follow-up activities/CQI projects
    - Provide CQM Team focused technical assistance, as needed
    - Identify and share best practices for appointment processes, people with HIV no show follow-up, rescheduling and re-engagement in care

that results in higher medical visit frequency rates and lower rates for gap in services
    - Require subrecipients to implement clinic specific CQI projects with the aim to improve these measures if they are not meeting state goals
- Improve Viral Load Suppression rate to reach state goal of 90%.
    - Use CAREWare data to assess, measure rate and monitor trends
    - Review processes for CAREWare data entry, ensure data integrity, and provide technical assistance, as needed
    - Encourage subrecipients to produce 'patient drill down' lists from CAREWare as tool for evaluation, to identify barriers and develop follow-up activities/CQI projects
    - Distribute to subrecipients the Pharmacy Benefit Manager (PBM) 'No Scripts Filled' report to monitor ADAP utilization **percentage rate for each enrollment site per number of enrollees identified at each location**
    - Engage CQM Peer/Consumer Representatives to provide feedback regarding barriers to accessing medication and suggestions to increase adherence to ADAP
    - Provide CQM Team focused technical assistance, as needed
    - Refer to sources for HIV Care training as needed
    - Identify and share best practices
    - Require subrecipients to implement clinic specific CQI projects with the aim to improve **HAB core** measures if they are not meeting state goals

APPENDICES

APPENDIX A

CLINICAL QUALITY MANAGEMENT WORK PLAN

GEORGIA RYAN WHITE PART B PROGRAM

FY2023-2024

CLINICAL QUALITY MANAGEMENT WORK PLAN

GOAL 1:

CONTINUOUSLY IMPLEMENT A STATEWIDE RYAN WHITE PART B CLINICAL QUALITY MANAGEMENT PLAN, THAT IS UPDATED AT LEAST ANNUALLY

OBJECTIVES	STRATEGIES	LEAD	STAFF RESOURCES	TIMELINE	PROGRESS NOTES
1-1 Provide quality improvement (QI) / quality management (QM) training based on identified needs.	1-1.a. Plan and conduct quality management trainings based on identified needs. 1-1.b. Share information on CQII training with CQI Core Team and subrecipients. 1-1.c. Share best practices during CQM Core Team meetings. 1-1.d. Collaborate with partners to implement clinical and/or case management training based on identified needs.	Sandra Metcalf Donnie Gillum Precious Jackson	CQM Core Team Care Team CQII Part A Part D GA AETC	1-1.a. As needed 1-1.b. As available 1-1.c. As available 1-1.d. As needed	

1-2 Assure that subrecipients conduct at least one Continuous Quality Improvement (CQI) project each year, to include any core measures that are below state goals.	1-2.a. Facilitate system improvements by utilizing CQI methodologies. 1-2.b. Review subrecipient CQI projects and provide technical assistance (TA). 1-2.c. Provide TA to subrecipient CQM committees. 1-2.d. Monitor subrecipient quarterly CQM reports for CQI and best practices. 1-2.e. Showcase CQI best practices. 1-2.f. Share updates and solicit input from CQM Core Team regarding statewide improvement efforts.	Sandra Metcalf Donnie Gillum Precious Jackson	CQM Core Team Care Team CQII District Liaisons Local CQM Committees	1-2.a. Quarterly 1-2.b. Quarterly 1-2.c. As needed 1-2.d. Quarterly 1-2.e. As available 1-2.f. Quarterly	
1-3 Communicate findings to key stakeholders at least biannually.	1-3.a. Present at statewide Part B Meetings and other applicable meetings. 1-3.b. Share progress reports with all Parts and across programs as appropriate, specifically share Work Plans with progress notes completed. 1-3.c. Update CQM information on the Office of HIV/AIDS web page.	Sandra Metcalf Donnie Gillum Precious Jackson	CQM Core Team Care Team	1-3.a. TBD 1-3.b. Quarterly 1-3.c. As needed	
1-4 Update the CQM Plan at least annually and the CQM Work Plan at least quarterly.	1-4.a. Revise CQM Plan annually and distribute to subrecipients.	Sandra Metcalf Donnie Gillum Precious Jackson	CQM Core Team Care Team	1-4.a. Annually 1-4.b. Annually 1-4.c. Annually 1-4.d. Quarterly	

	1-4.b. Share CQM Plan with DPH and Office of HIV/AIDS stakeholders. 1-4.c. Place revised CQM Plan on Office of HIV/AIDS web pages. 1-4.d. Revise Work Plan quarterly and share during CQM Core Team meetings.				
1-5 Require that all RW Part B Program subrecipients revise written CQM Plans annually, Work Plans quarterly, and submit quarterly CQM progress reports to include CQI project updates.	1-5.a. Obtain quarterly CQM reports from subrecipients and monitor CQM activities, CQI project updates and performance measures. 1-5.b. Review revised CQM Plans from subrecipients. 1-5.c. Provide feedback on local CQM Plans to subrecipients.	Sandra Metcalf Donnie Gillum Precious Jackson District Liaisons	District HIV Coordinators Local CQM Committees CQM Core Team	1-5.a. Quarterly 1-5.b. Annually 1-5.c. **as needed**	
GOAL 2: IMPROVE EFFICIENCY OF THE GEORGIA AIDS DRUG ASSISTANCE PROGRAM (ADAP)					
OBJECTIVES	STRATEGIES	LEAD	STAFF RESOURCES	TIMELINE	PROGRESS NOTES
2-1 Monitor viral load suppression among people with HIV **enrolled in ADAP to** maintain viral load	2-1.a. Create quarterly report from the CAREWare database. 2-1.b. Utilize the report to communicate with the	Satin Francis	Alysia Johnson CAREWare Data Team	2-1.a. Quarterly 2-1.b. Quarterly 2-1.c. As needed	

suppression at **75**% or greater.	district and enrollment staff 2-1.c. Share findings with ADAP/HICP CQM Subcommittee as needed				
2-2 Monitor the percentage of new ADAP applications that were determined to be approved in the measurement quarter at 90% or greater.	2-2.a. Generate quarterly reports to monitor this objective and share with the enrollment sites and CQM Core team. 2-2.b. Evaluate reports for trends in ADAP Office of HIV/AIDS performance in processing applications. 2-2.c. Utilize reports to communicate with district and agency staff regarding their rates of correctly completed ADAP application submissions. 2-2.d. Provide technical assistance on ADAP applications and required supporting documentation to staff and agencies. 2-2.e. Ensure that ADAP coordinators and case managers comply with the approved Georgia Ryan White Part B/ADAP/HICP Policies and Procedures. 2-2.f. Provide or coordinate ADAP-related training for ADAP/ HICP enrollment site	Satin Francis Alysia Johnson CAREWare Data Team	Case Management Team ADAP Team	2-2.a. Quarterly 2-2.b. Quarterly 2-2.c. Quarterly 2-2.d. As needed 2-2.e. During internal review as needed 2-2.f. As needed 2-2.g. As needed 2-2.h. As needed	

	coordinators and case managers. 2-2.g. Communicate Georgia ADAP updates via **teleconference** calls, email listserv, and Office of HIV/AIDS web pages. 2-2.h. Convene the ADAP/HICP CQM Subcommittee as needed.				
2-3 Monitor the percentage of ADAP annual recertifications that were determined to be approved in the measurement quarter at 90% or greater.	2-3.a. Generate quarterly reports to monitor this objective and share with the enrollment sites and ADAP/HICP CQM Subcommittee as needed. 2-3.b. Utilize reports to communicate with district and agency staff regarding people with HIV recertification status. 2-3.c. Monitor the ADAP enrollment sites systems to track ADAP people with HIV recertification due dates. 2-3.d. Provide technical assistance to those who need assistance developing or improving their system to track ADAP people with HIV recertification due dates. 2-3.e. Ensure that ADAP coordinators and case managers comply with the	Satin Francis Alysia Johnson CAREWare Data Team	Case Management Team ADAP Team	2-3.a. Quarterly 2-3.b. Monthly 2-3.c. Monthly 2-3.d. As needed 2-3.e. Ongoing 2-3.f. As needed 2-3.g. Annually 2-3.h. As needed 2-3.i. As needed	

	approved Georgia ADAP Policies and Procedures manual. 2-3.f. Provide or coordinate ADAP related training for ADAP/ HICP enrollment site coordinators and case managers. 2-3.g. Conduct administrative site visits. 2-3.h. Communicate Georgia ADAP updates via **teleconference** calls, email listserv and Office of HIV/AIDS web pages. 2-3.i. Convene the ADAP/ HICP CQM Subcommittee as needed.				
2-4 Conduct an internal audit of up to 5% of ADAP applications.	2-4.a. Review complete audit of all active people with HIV files. 2-4.b. Utilize the "ADAP Documentation Checklist" to evaluate if ADAP applications and forms were correctly completed and if approved or denied according to ADAP policies and procedures. 2-4.c. For applications and forms that were incomplete, request and obtain required documentation.	Satin Francis Alysia Johnson	ADAP Team CQM Team	2-4.a. Daily 2-4.b. Daily 2-4.c. As needed 2-4.d. Quarterly 2-4.e. Quarterly 2-4.f. As needed	

	2-4.d. Create quarterly Report Card from CAREWare summarizing key findings. 2-4.e. Share findings with ADAP district or agency enrollment sites. 2-4.f. Share findings with the ADAP/HICP CQM Subcommittee to initiate CQI projects as indicated.				
2-5 Monitor **medication** compliance and adherence to antiretroviral regimens through the **third-party administration** system.	2-5.a. Review PBM compliance/ adherence reports. 2-5.b. Provide medication adherence training to ADAP contract pharmacies. 2.5.c. Conduct ACP Network audits.	Gay Campbell Satin Francis	Alysia Johnson Donnie Gillum Precious Jackson	2-5.a. Quarterly 2-5.b. As needed 2-5.c As needed	
2-6 Systematically review ADAP **clinical and claims** data to identify inappropriate antiretroviral therapy (ART) regimens or components.	2-6.a. Review PBM reports and pharmacy audit tools to monitor inappropriate ART regimens or components. 2-6.b. Utilize PBM reports and pharmacy audit tools to provide training and assistance to ACP Network regarding inappropriate ART regimens or components. 2-6.c. Provide access to current **DHHS HIV guideline** updates and **other** related medication	Gay Campbell	Medical Consultant	2-6.a. Quarterly and as needed 2-6.b. As needed and during audits 2-6.c. As occurs and needed	

	guidelines and resources for ACP Network, **and other clinical partners.**				
GOAL 3: **IMPROVE EFFICIENCY OF THE GEORGIA HEALTH INSURANCE CONTINUATION PROGRAM (HICP)**					
OBJECTIVES	STRATEGIES	LEAD	STAFF RESOURCES	TIMELINE	PROGRESS NOTES
3-1 Monitor viral load suppression among people with HIV **enrolled in HICP to** maintain viral load suppression at 85% or greater.	3-1.a. Create quarterly report from the CAREWare database 3-1.b. Utilize the reports to communicate with the district and enrollment staff 3-1.c. Share findings with ADAP/HICP CQM Subcommittee **as needed**.	Satin Francis	Alysia Johnson CAREWare Data Team	3-1.a. Quarterly 3-1.b. Quarterly 3-1.c. As needed	
3-2 Monitor the percentage of new HICP applications that were determined approved in the measurement quarter at 90% or greater.	3-2.a. Generate monthly reports to monitor this objective. 3-2.b. Utilize reports to communicate with district and agency staff regarding people with HIV recertification status. 3-2.c. Provide technical assistance on HICP applications and backup documentation to staff and agencies as needed.	Satin Francis Alysia Johnson CAREWare Data Team	HICP Team District Liaisons CQM Team	3-2.a. Monthly 3-2.b. Monthly 3-2.c. As needed 3-2.d. During internal reviews as needed 3-2.e. As needed 3-2.f. Quarterly or by request 3-2.g. Quarterly 3-2.h. As needed	

	3-2.d. Encourage adherence to the Georgia Ryan White Part B/ADAP/HICP Policies and Procedures by the ADAP/ HICP enrollment sites. 3-2.e. Ensure that ADAP/HICP coordinators and case managers are aware of updates to the Georgia Ryan White Part B/ADAP/HICP Policies and Procedures. 3-2.f. Provide or coordinate HICP related training for ADAP/ HICP enrollment site coordinators and case managers. 3-2.g. Communicate Georgia RW Part B HICP updates via **teleconference** calls, email listserv, and Office of HIV/AIDS web pages. 3-2.h. Convene the ADAP/ HICP CQM Subcommittee as needed.				
3-3 Monitor the percentage of HICP annual recertifications that were determined to be approved in the measurement quarter at 90% or greater.	3-3.a. Generate quarterly reports to monitor this objective and share quarterly with the ADAP/HICP CQM Subcommittee as needed. 3-3.b. Utilize the reports to communicate with the	Satin Francis Alysia Johnson CAREWare Data Team	HICP Team District Liaisons CQM Team	3-3.a. Quarterly 3-3.b. Quarterly 3-3.c. As needed 3-3.d. Daily 3-3.e. As needed	

	district and enrollment staff 3-3.c. Provide technical assistance on HICP applications and backup documentation to staff and/or agency as needed 3-3.d. Ensure that HICP coordinators and case managers comply with the approved Georgia Ryan White Part B/ADAP/HICP Policies and Procedures 3-3.e. Provide or coordinate HICP related training for ADAP/HICP enrollment site coordinators and case managers as needed.				
3-4 Conduct an annual audit of HICP applications and/or recertifications.	3-4.a. Review complete audit of all active people with HIV files. 3-4.b. Utilize the "HICP Documentation Checklist" to evaluate if HICP applications or recertification forms were correctly completed and if approved or denied according to HICP policies and procedures. 3-4.c. For application forms that were incomplete, request and obtain required documentation.	Satin Francis Alysia Johnson	HICP Team CQM Team	3-4.a. Annually 3-4.b. Daily 3-4.c. As needed 3-4.d. Quarterly 3-4.e. As needed	

	3-4.d. Create quarterly report card from CAREWare summarizing key findings. 3-4.e. Share findings with the ADAP/HICP CQM Subcommittee to initiate CQI projects as indicated.				
GOAL 4: IMPROVE THE QUALITY OF HEALTH CARE AND SUPPORTIVE SERVICES					
OBJECTIVES	STRATEGIES	LEAD	STAFF RESOURCES	TIMELINE	PROGRESS NOTES
4-1 Monitor performance measures (PMs), including stratified core measures, in all subrecipients.	4-1.a. Include HAB PMs in monitoring tools, chart reviews and CQM Plans. 4-1.b. Generate quarterly reports from CAREWare on the HAB PMs and share with HIV Coordinators. 4-1.c. Provide technical assistance to improve the accuracy of CAREWare HAB PM data and reports. 4-1.d. Conduct clinical and case management chart reviews.	Sandra Metcalf Donnie Gillum Precious Jackson CAREWare Data Team Medical Consultant	CQM Core Team District Liaisons	4-1.a. As **indicated** 4-1.b. Quarterly 4-1.c. As needed 4-1.d. Biennial	
4-2 Continue CQI project to improve core measures for HIV	4-2.a. Use CQI methodologies throughout the project.	Sandra Metcalf Donnie Gillum Precious Jackson	CQM Core Team Care Team	4-2.a. Ongoing 4-2.b. Quarterly 4-2.c. As needed	

Medical Visit Frequency and Gap in HIV Medical Visits to attain state goals of 85% and 10% respectively.	4-2.b. Track statewide data for decreased rate for HIV Medical Visit Frequency and/or increased rate for Gap in HIV Medical Visits via HAB Report. 4-2.c. Consult with subrecipients and CAREWare team to increase knowledge of data entry processes, ensure data integrity and provide technical assistance. 4-2.d. Review CQM Quarterly Reports for CQI Projects targeting these PMs and missed appointment follow-up data. 4-2.e. Provide CQM Team focused technical assistance. 4-2.f. Share best practices with subrecipients. 4-2.g. Provide TA to subrecipients in development of CQI projects to improve on measures for HIV Medical Visit Frequency and Gap in HIV Medical Visits.	CAREWare Data Team	Subrecipient staff and CQM committees Consumer Representatives CQII	4-2.d. Quarterly 4-2.e. As needed 4-2.f. As available 4-2.g. As needed	
4-3 Continually monitor the Acuity Scale and Self-Management Model.	4-3.a. Conduct CM Chart Reviews 4-3.b. Provide technical assistance to subrecipients	Donnie Gillum Precious Jackson	CQM Core Team	4-3.a. Biennial and as needed 4-3.b. As needed	

	for case management strategies and techniques to increase success from best practice methodologies.				
4-4 Implement the *Georgia HIV/AIDS Case Management Standard Operating Procedures* (SOPs).	4-4.a. Revise CM SOPs annually. 4-4.b. Distribute CM SOPs to subrecipient HIV Coordinators with summary of revisions **and including the standard electronic forms used for CM processes**. 4-4.c. Place revised CM SOPs on Office of HIV/AIDS web pages. 4-4.d. Provide technical assistance to subrecipients to assist with implementation of the CM SOPs.	Donnie Gillum Precious Jackson	CQM Core Team	4-4.a. Annually 4-4.b. Annually 4-4.c. Annually 4-4.d. As needed	
4-5 Participate in quality-related activities across Ryan White Programs (Parts A, B, C, and D) in Georgia.	4-5.a. Attend Part A and Part D CQM Committee meetings and Part A Planning Council meetings as available. 4-5.b. Include across Ryan White Programs representation on the Part B CQM Core Team. 4-5.c. Provide quality-related training to RW staff statewide based on identified needs.	Sandra Metcalf Donnie Gillum Precious Jackson	Part A CQM Committee Part D CQM Committee Part B CQM Core Team GA AETC GPACC	4-5.a. As scheduled 4-5.b. Ongoing 4-5.c. As needed 4-5.d As needed 4-5.e TBD	

	4-5.d. Coordinate quality training efforts with GA AETC. 4-5.e. Participate in Integrated Planning efforts.				
4-6 The percent of pregnant **clients** with HIV prescribed antiretroviral therapy will be 95% or greater.	4-6.a. As part of the RW Part B Program clinical chart review, assess management of pregnant **clients** with HIV. 4-6.b. Monitor HAB05 Percentage of pregnant **clients** prescribed ART on quarterly HAB Report.	Medical Consultant Sandra Metcalf	CQM Core Team	4-6.a. Biennial and as needed 4-6.b. Quarterly	
4-7 Monitor, assess and improve perinatal systems of care for **clients** with HIV and their infants.	4-7.a. Collaborate with WIC to incorporate HIV content into the breastfeeding classes to address risk of mother-to-child transmission 4-7.b. **Create an electronic reporting mechanism system to allow private and public providers to report high-risk pregnant mothers and exposed infants.** 4-7.c. Create Standard Operating Procedure (SOP) for all RW Part A, B, C, D providers, case managers, and referred Obstetricians & Gynecologists to improve the coordination of care	Crystal Fuller	WIC Perinatal Working Group CQM Core Team	4-7.a. Ongoing 4-7.b. **As needed** 4-7.c. Ongoing 4-7.d. Ongoing	

	between prenatal care and HIV care. 4-7.d. Partner with Georgia AIDS Education Training Center (GA AETC) to work directly with hospitals and providers to enhance clinical practice in prevention of mother-to-child transmission of HIV.				
4-8 Continue CQI Project to improve the statewide Viral Load Suppression rate and attain state goal of 90%.	4-8.a. Use CQI methodologies throughout the project. 4-8.b. Track statewide data for Viral Load Suppression via HAB Report, including disparities stratification to inform quality improvement activities. 4-8.c. Consult with subrecipients and CAREWare team to increase knowledge of data entry processes, ensure data integrity and provide technical assistance. 4-8.d. Distribute to subrecipients the PBM report 'No Scripts Filled' to monitor ADAP utilization. 4-8.e. Engage CQM Peer/Consumer Representatives to provide feedback regarding barriers to **accessing care**,	Sandra Metcalf Donnie Gillum Precious Jackson CAREWare Data Team	CQM Core Team Care Team ADAP staff Subrecipient staff and CQM Committees Consumer Representatives CQII	4-8.a. Ongoing 4-8.b. Quarterly 4-8.c. As needed 4-8.d. Monthly 4-8.e. TBD 4-8.f. Monthly 4-8.g. Quarterly 4-8.h. As needed 4-8.i. As needed 4-8.j. As available 4-8.k. As needed	

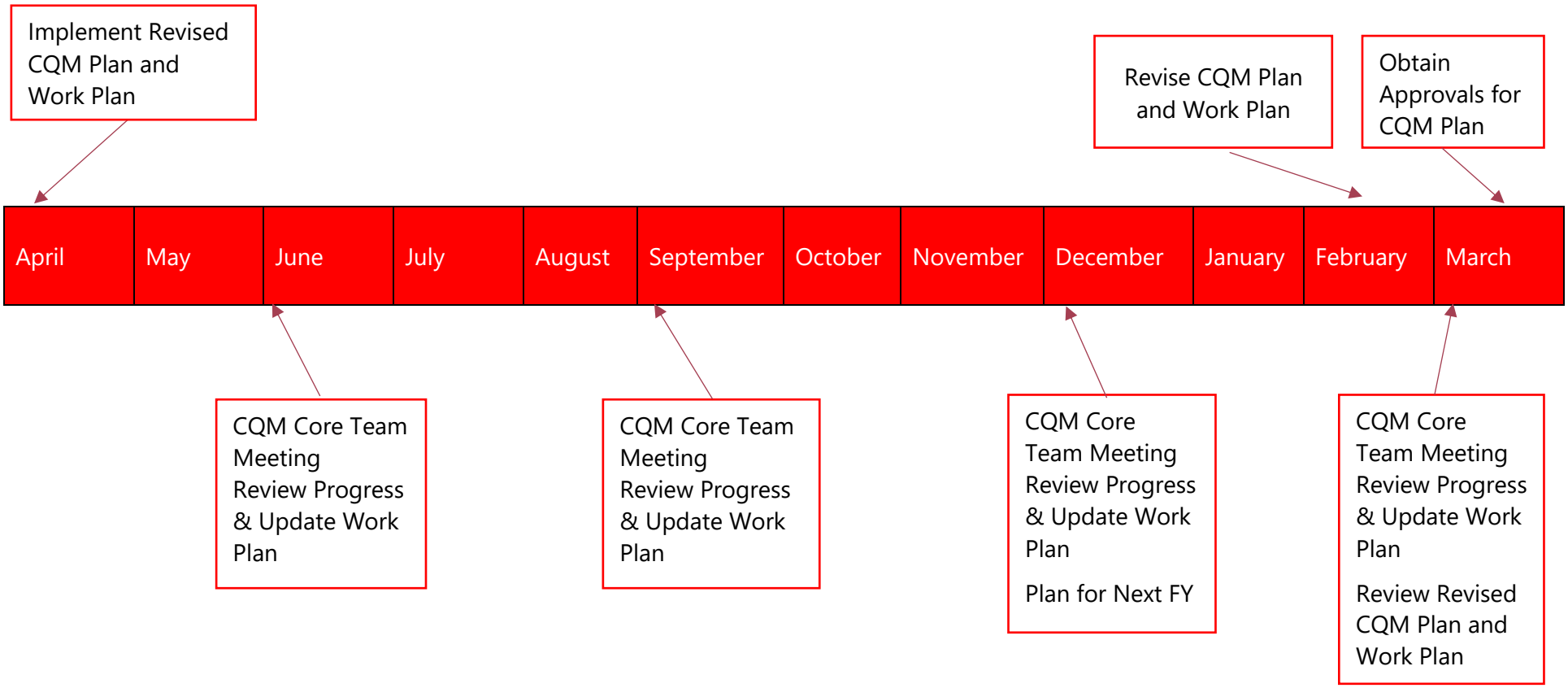
	accessing medication and suggestions to increase adherence to ADAP. 4-8.f. **Utilization of the ADAP 'No Scripts Filled' report to assess ART adherence for actively enrolled clients with an active ART prescription on file within the program by working with all ADAP/HICP enrollment sites, case managers and other identified staff for better ADAP utilization and improving HIV viral load suppression.** 4-8.g. Review CQM Quarterly Reports for CQI Projects targeting Viral Load Suppression. 4-8.h. Provide CQM Team focused technical assistance. 4-8.i. Refer to sources for HIV Care training. 4-8.j. Share best practices with subrecipients. 4-8.k. Provide TA to subrecipients in development of CQI projects to improve Viral Load Suppression rates.				

4-9 Monitor measures to verify compliance with HRSA regulations related to the 'vigorous pursuit' and payer of last resort.	4-9.a. Communicate updates as they are received. 4-9.b. Provide technical assistance based on identified needs, including tools to assist subrecipients with compliance.	Mirelys Ramos Rolanda Hall DeWan Green Emory Searcy Shandrecka Murphy Pamela Henry	HIV Care Team	4-9.a. As needed 4-9.b. As needed	
4-10 Monitor compliance with RW Part B Program and Emerging Communities (EC) program requirements.	4-10.a. Conduct site visits and provide summary reports, including feedback as appropriate. 4-10.b. Update site visit tools for subrecipients and contractors in accordance with federal program requirements. 4-10.c. Assess services provided at the district level and share common findings with the CQM Core Team. 4-10.d. Provide technical assistance to subrecipients in need of compliance support. 4-10.e. Develop processes to improve compliance with RW Part B Program and EC program requirements for applicable subrecipients.	Mirelys Ramos Rolanda Hall DeWan Green Emory Searcy Shandrecka Murphy Pamela Henry	HIV Care Team	4-10.a. Ongoing 4-10.b. Annually 4-10.c. Quarterly and as needed 4-10.d. As needed 4-10.e. As needed	

APPENDIX B

CLINICAL QUALITY MANAGEMENT PLAN ANNUAL TIMELINE

CLINICAL QUALITY MANAGEMENT PLAN TIMELINE



APPENDIX C

GEORGIA RYAN WHITE PART B PROGRAM
CLINICAL QUALITY MANAGEMENT COMMITTEES

CLINICAL QUALITY MANAGEMENT CORE TEAM MEMBERS

- Adolphus Major, Lead Consumer Advocate/ Program Assistant
- Alysia Johnson, BHS, ADAP/HICP Assistant Manager
- Asfia Mohammed, Grants Administrator
- Brian Easom, MPH, Director of The Hope Center
- Chervonne Smith, FNP-C
- Christopher Pride, MSN, AGPCNP-BC, Interim Director of Clinical Care Department
- Crystal Fuller, HIV Perinatal Coordinator
- Deborah "Deb" Bauer, MPH, Ryan White (Part D)
- DeWan Green, MPA, District Liaison
- Donnie Gillum, BSCJ, MBA HM, Ryan White Part B Quality Clinical Case Manager
- Emory Searcy, District Liaison
- Gay Campbell, RPh, ADAP Pharmacy Director
- Heather Wademan, LCSW, Quality and Compliance Manager
- Jamila Booker, Quality Coordinator
- Janet Eberhart, RN-BSN, Ryan White Program Coordinator
- Jeffery Vollman, MPA, District HIV Director
- Kathryn 'Kate' Gambo, Business Operations Manager
- Kenisha Washington, Program Manager (Part F)
- Lisa Cowan, MA, MPA, HIV Data Team Manager
- Malela Rozier, MSW, MA, BS, HIV Program Coordinator
- Marisol Cruz, DBA, MS, HIV Care Manager
- Maira Colón, Interim HIV Program Manager
- Masonia Traylor, Peer Advocate
- Mirelys M. Ramos, MPH, CHES, Assistant HIV Care Manager
- Naranza Tucker, Public Health Lab Tech
- Pamela Henry, BS, Ryan White Part B District Financial Liaison
- Pamela Phillips, Quality Management Specialist (Part A)

- Precious Jackson, MA, Ryan White Part B Quality Clinical Case Manager
- Remy Hutchins, RN, BSN, MPH, Infectious Disease Program Director
- Roderick Newkirk, Database Analyst II
- Rolanda Hall, MPH, District Liaison
- Sandra Metcalf, MPH, RN, ACRN, QM Nurse Consultant Team Lead
- Satin Francis, BS, ADAP/HICP Program Manager
- Shandrecka Murphy, MPH, District Liaison
- Shelby Freeman, MPH, LMSW, Wellness Program Manager
- Suzette Thedford, MPH, Quality Program Analyst
- Teresa Hritz, RN Infectious Disease Coordinator
- Vivian Momah, MPH HIV Prevention & Care Planning Group Coordinator

CLINICAL QUALITY MANAGEMENT ALTERNATE CORE TEAM MEMBERS

- Althea Mims-Daniels, Healthcare Program Consultant Supervisor
- A'lea Dawkins, RN BSN
- Ann Phosai
- Audrey Brown, MD
- Barbara Flowers, Interim Patient Care Coordinator Supervisor
- Beth Spivey, BSN RN ACRN
- Debbie Hagins, MD
- Erin Wust, RN BSN, Nurse Manager
- Gabriel Silva, LCSW
- Ginny Price, RN Case Manager
- Jennifer Chastain, BSN RN, Specialty Care Clinic Manager
- Kenisha Washington, Ryan White Program Coordinator
- LaToya Robinson, MS, HIV Program Assistant Director/ADAP Coordinator
- Melissa Beaupierre, MPH CPH, Manager, Policy & Contracts
- Nicole Roebuck, MSW, Executive Director
- Sheryl Lewis, MBA, Program Consultant
- Veronica Jimenez, RN Case Manager

CLINICAL QUALITY MANAGEMENT ADAP/HICP SUBCOMMITTEE MEMBERS

- Alysia Johnson, BHS, ADAP/HICP Assistant Manager
- Precious Jackson, RW Part B Quality Clinical Case Manager
- Donnie Gillum, RW Part B Quality Clinical Case Manager
- Gay Campbell, RPh, ADAP Pharmacy Director
- Medical Consultant, Division of Medical and Clinical Program Services - HIV Office
- Marisol Cruz, DBA, MS, HIV Care Manager
- Mirelys M. Ramos, MPH, CHES, Assistant HIV Care Manager
- Sandra Metcalf, MPH, RN ACRN, HIV QM Nurse Consultant Team Lead
- Satin Francis, ADAP/HICP Program Manager

APPENDIX D

SERVICE CATEGORY PERFORMANCE MEASURE TABLE

SERVICE CATEGORY PERFORMANCE MEASURE TABLE

Performance measures are assigned to funded service categories as per HRSA/HAB guidance provided in CQM Policy Clarification Notice 15-02. Additional Performance Measures are included in Appendix E.

Service Category	Performance Measure	Description	Numerator	Denominator
Outpatient/Ambulatory Medical Care	Viral Load Suppression	Percentage of people with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year	Number of people in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	Number of people with HIV who had at least one medical visit in the measurement year
	Viral Load Suppression among black Men Who Have Sex with Men (MSM) (Indicator 6b)*	Percentage of black MSM with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year	Number of black MSM in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	Number of black MSM with HIV who had at least one medical visit in the measurement year
	Viral Load Suppression among Latino MSM (Indicator 6c)*	Percentage of Latino MSM with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year	Number of Latino MSM in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	Number of Latino MSM with HIV who had at least one medical visit in the measurement year

Service Category	Performance Measure	Description	Numerator	Denominator
	Prescription of Antiretroviral Therapy	Percentage of people with HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year	Number of people in the denominator prescribed HIV antiretroviral therapy during the measurement year	Number of people with HIV who had at least one medical visit in the measurement year
	HIV Medical Visit Frequency	Percentage of people with HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits	Number of people in the denominator who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period	Number of people with HIV who had at least one medical visit in the first 6-months of the 24-month measurement period
	Gap in HIV Medical Visits	Percentage of people with HIV who did not have a medical visit in the last 6 months of the measurement year	Number of people in the denominator who did not have a medical visit in the last 6 months of the measurement year	Number of people with HIV who had at least one medical visit in the first 6 months of the measurement year

Service Category	Performance Measure	Description	Numerator	Denominator
Medical Case Management	HIV Medical Visit Frequency	Percentage of people with HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits	Number of people in the denominator who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the subsequent 6-month period	Number of people with HIV who had at least one medical visit in the first 6-months of the 24-month measurement period
	Gap in HIV Medical Visits	Percentage of people with HIV who did not have a medical visit in the last 6 months of the measurement year	Number of people in the denominator who did not have a medical visit in the last 6 months of the measurement year	Number of people with HIV who had at least one medical visit in the first 6 months of the measurement year
Non-Medical Case Management	HIV Medical Visit Frequency	Percentage of people with HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits	Number of people in the denominator who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the subsequent 6-month period	Number of people with HIV who had at least one medical visit in the first 6-months of the 24-month measurement period
	Gap in HIV Medical Visits	Percentage of people with HIV who did not have a medical visit in the last 6 months of the measurement year	Number of people in the denominator who did not have a medical visit in the last 6 months of the measurement year	Number of people with HIV who had at least one medical visit in the first 6 months of the measurement year

Service Category	Performance Measure	Description	Numerator	Denominator
AIDS Drug Assistance Program	HIV Viral Load Suppression among ADAP enrolled	Percentage of ADAP enrolled people with HIV with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year	Number of ADAP enrolled people in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test within one year of end date of quarter measured	Number of ADAP enrolled people with HIV and any ADAP service in the quarter measured
	Completion of new ADAP applications	Percentage of new ADAP applications that were determined to be complete, incomplete, pending, approved, or denied in the measurement quarter	Number of applications in the denominator that were approved in the measurement quarter	All ADAP applications received in the quarter measured
			Number of applications in the denominator that were denied in the measurement quarter	
			Number of applications in the denominator that were pending (submitted prior to end of quarter but not yet processed) in the measurement quarter	
			Number of applications in the denominator that were submitted correctly in the measurement quarter	
			Number of applications in the denominator that were submitted incorrectly in the measurement quarter	

Service Category	Performance Measure	Description	Numerator	Denominator
Health Insurance Continuation Program	HIV Viral Load Suppression among HICP enrolled	Percentage of HICP enrolled people with HIV with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year	Number of HICP enrolled people in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test within one year of end date of quarter measured	Number of HICP enrolled people with HIV and any HICP service in the quarter measured
*National HIV/AIDS Strategy for the United States 2022-2025				

APPENDIX E

CLINICAL QUALITY MANAGEMENT MONITORING TABLE

CLINICAL QUALITY MANAGMENT MONITORING TABLE

Criteria	Indicators	Data Elements	Data Sources & Methods
GENERAL RYAN WHITE PROGRAM PERFORMANCE MEASURES			
Ryan White funds are used as payer-of-last-resort.	People with HIV screened for other health care providers and insurance. Eligible people with HIV referred for enrollment into private insurance, Medicare, or Medicaid	Documentation **within the medical record** indicating that people with HIV are screened at intake and recertified every 12 months. Documentation **within the medical record** that people with HIV are referred for enrollment into private insurance, Medicare, or Medicaid.	Record review
Eligibility documented for all people with HIV receiving Ryan White Part B Program services: • HIV status • Income • Proof of residency • Other health care coverage	Documented HIV positive status. Documentation of financial screening initially then every 12 months; and income at or below 400% of Federal Poverty Level (FPL). Documentation of Georgia residency. Eligibility for other funding sources is vigorously and consistently pursued (i.e., Medicaid, Children's Health Insurance Program (CHIP), Medicare, or State-funded HIV programs, and/or private sector funding, including private insurance).	Documentation **within the medical record** of HIV test result or physician signed statement of HIV infection. Documentation **within the medical record** of financial screening, proof of residency, and health care coverage status at intake and every 12 months.	Record review

Criteria	Indicators	Data Elements	Data Sources & Methods
Ryan White-funded providers coordinate the delivery of services and funding mechanisms with other programs or providers.	Memoranda of agreements (MOA) exist with community partners. Contracts executed for subcontracted services. Subrecipients conducted site visits where subcontracted services are provided.	MOA on file. Contracts on file. Documentation of site visits to subcontractors and evaluation of the quality of services provided by subcontractors.	Review of MOAs and contracts. Site visit reports for subcontractors. Evaluation of the quality of services, such as performance measure reports and people with HIV satisfaction surveys.
People with HIV security and confidentiality maintained.	Employees' signed confidentiality agreements. Charts secured under lock. Electronic records are password protected. Access to areas with medical records and computers restricted.	Signed confidentiality agreements. Locked storage area for people with HIV charts and other information. Computers are password protected and secure while in use. Layout of clinic prevents unauthorized access to records and computers.	Review of employee files. Observation of security and confidentiality measures. Review of written policy and procedures regarding security and confidentiality.
Ryan White funded providers ensure that every person with HIV is informed about policies for: • HIV confidentiality • Grievance procedures • People with HIV rights and responsibilities	Percent of people with HIV informed of confidentiality policy, grievance policies and procedures, and rights and responsibilities.	Documentation in chart that people with HIV are informed of confidentiality policy, grievance policies and procedures, and rights and responsibilities initially then annually.	Record review

Criteria	Indicators	Data Elements	Data Sources & Methods
People with HIV are satisfied with the Ryan White Part B Program services they receive.	Percent of people with HIV who indicate they are satisfied with the services they have received.	People with HIV responses to questions about their satisfaction with specific services.	Review of district level people with HIV annual satisfaction survey summary results.
Ryan White-funded providers implement CQM Plans with Continuous Quality Improvement (CQI) projects.	Percent of Ryan White Part B-funded programs with written clinical quality management plans and a current report of CQI activities and results.	Written clinical quality management plan. Copies of the most current report of CQI activities and results.	Review of clinical quality management plans and reports.
CASE MANAGEMENT PERFORMANCE MEASURES			
All newly enrolled or reactivated case managed people with HIV will have an Intake, Acuity Scale, and Individualized Service Plan (ISP), and case note documentation completed within 15-30 days of initial intake assessment.	Percent of newly enrolled or reactivated case managed people with HIV charts with an Intake, Acuity Scale, and Individualized Service Plan (ISP), and progress/case note completed within 15-30 days of initial intake assessment based on level of acuity in accordance with the Activities by Acuity Document.	N: Number of newly enrolled or reactivated case managed people with HIV charts with an Intake, Acuity Scale, and Individualized Service Plan (ISP), and progress/case note completed within 15-30 days of initial intake assessment during the measurement year. D: Number of newly enrolled or reactivated case managed people with HIV during the measurement year.	Chart Review
Ensure that the Acuity Scale is updated every 3-6 months in accordance with the Activities by Acuity Level Document.	Percent of charts that have an Acuity Scale updated every 3-6 months in accordance with the Activities by Acuity Level Document during the measurement period.	N: Number of charts that had an Acuity Scale updated every 3-6 months in accordance with the Activities by Acuity Level Document during the measurement year. D: Number of case management charts that had an updated Acuity Scale during the measurement year.	Chart Review

Criteria	Indicators	Data Elements	Data Sources & Methods
All case managed people with HIV must have re-evaluation and adaptation of the ISP at least every 3-6 months in accordance with the Activities by Acuity Document.	Percent of case management people with HIV charts with documented evidence of periodic re-evaluation and adaptation of the ISP at least every 3-6 months.	N: Number of case management people with HIV charts with documented evidence of periodic re-evaluation and adaptation of the ISP at least every 3-6 months at least 3 months apart during the measurement year. D: Number of case managed people with HIV in a measurement year.	Chart review
Ensure that people with HIV receiving case management services have continuous monitoring to assess the efficacy of the ISP.	Percent of charts with documented evidence of ongoing monitoring to assess the efficacy of the ISP.	N: Number of charts with documented evidence of ongoing monitoring to assess the efficacy of the ISP during the measurement year. D: Number of medically case managed people with HIV in a measurement year.	Chart review
Ensure that people with HIV receiving medical case management (MCM) services (newly diagnosed and acuity level 4) have documentation which includes coordination and follow up of medical treatment. **Some newly diagnosed clients may not need MCM-self managed.**	Percent of charts (newly diagnosed and acuity level 4) documentation which includes coordination and follow-up of medical treatment.	N: Number of MCM charts (newly diagnosed and acuity level 4) with documentation including coordination and follow-up of medical treatment. D: Number of MCM people with HIV in a measurement year.	Chart review
People with HIV receiving MCM services (newly diagnosed and acuity level 4) will have treatment adherence assessed at least every 3 months. **Some newly diagnosed clients may not need MCM-self managed.**	Percent of MCM people with HIV (**newly diagnosed and acuity level 4**) charts with a documented treatment adherence visit **at least 1 time not more than** 3 months apart.	N: Number of MCM people with HIV (**newly diagnosed and** acuity level 4) with a documented treatment adherence visit **at least 1 time not more than** 3 months apart in a measurement year. D: Number of MCM people with HIV in the measurement year.	Chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
All MCM people with HIV (newly diagnosed and acuity level 3-4) who did not have a medical visit in the last 6 months as documented by case manager. **Some newly diagnosed clients may not need MCM-self managed.**	Percent of MCM people with HIV (newly diagnosed and acuity level 3-4) charts which did not have a medical visit in the last 6 months.	N: Number of MCM people with HIV (newly diagnosed and acuity level 3-4) charts that did not have a medical visit in the last 6 months during the measurement year. D: Number of case managed people with HIV in a measurement year.	Chart review
All MCM people with HIV charts (newly diagnosed acuity level 3-4) who had at least one medical visit in the 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit as documented by the case manager.	Percent of MCM people with HIV charts (newly diagnosed acuity level 3-4) that had at least one medical visit in the 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit.	N: Number of MCM people with HIV charts (newly diagnosed acuity level 3-4) that had at least one medical visit in the 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit during the measurement year. D: Number of MCM people with HIV in a measurement year.	Chart review
All case managed people with HIV chart documentation must reflect assistance with linkages to programs (health care, psychosocial and other services, as well as assist to access other public and private programs) for which people with HIV are eligible.	Percent of people with HIV chart documentation must reflect assistance with linkage to other programs for which people with HIV are eligible.	N: Number of people with HIV charts with documentation reflecting assistance with linkage to other programs for which people with HIV are eligible during the measurement year. D: Number of case managed people with HIV in a measurement year.	Chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
All case managed people with HIV (all levels of acuity) must have documented evidence of ongoing assessment of people with HIV and other key family members' needs, and personal support system as needed.	Percent of people with HIV charts (all levels of acuity) with documented evidence of ongoing assessment of people with HIV and other key family members' needs and personal support system, as needed.	N: Number of people with HIV charts (all levels of acuity) with documented evidence of ongoing assessment of people with HIV and other key family members' needs and personal support system, as needed. D: Number of case managed people with HIV in the measurement year.	Chart review
Documentation should reflect that people with HIV specific advocacy has occurred during service provision (all levels of acuity).	Percent of people with HIV charts with documented evidence of people with HIV advocacy (i.e., promotion of people with HIV needs for: transportation, housing or/and scheduling of appointments) has occurred during service provision.	N: Number of people with HIV charts with documented evidence of people with HIV advocacy (i.e., promotion of people with HIV needs for: transportation, housing or/and scheduling of appointments) has occurred during service provision in a measurement year. D: Number of case managed people with HIV in the measurement year.	Chart review
Ensure that benefits/entitlement counseling and referral services were provided to access other public and private programs, as needed to eligible people with HIV for all levels of acuity.	Percent of people with HIV charts with documented evidence that benefits/entitlement counseling and referral services were provided.	N: Number of people with HIV charts with documented evidence that benefits/entitlement counseling and referral services were provided in the measurement year. D: Number of case managed people with HIV in the measurement year.	Chart review
Case management people with HIV documentation (all levels of acuity) must ensure that housing referrals include: housing assessment, search, placement, advocacy, and financial assistance received for which people with HIV are eligible.	Percent of case managed people with HIV charts with documented housing referrals include: housing assessment, search, placement, advocacy, and financial assistance received.	N: Number of case managed people with HIV charts with documented housing referrals include housing assessment, search, placement, advocacy, and financial assistance received in the measurement year. D: Number of case managed people with HIV in the measurement year.	Chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
Case managed people with HIV documentation (all levels of acuity) must reflect that people with HIV received assistance in obtaining stable long-term housing as needed.	Percent of case managed people with HIV charts with documentation reflecting that people with HIV received assistance in obtaining stable long-term housing.	N: Number of case management people with HIV chart with documentation reflecting that people with HIV received assistance in obtaining stable long-term housing in the measurement year. D: Number of case managed people with HIV in the measurement year.	Chart review
All case management chart documentation of services and encounters must include: • Proof of RW Part B eligibility exists for Part B funded services • People with HIV identifier on all pages • Date of each encounter • Types of services provided • Types of encounters/ communication (i.e., face-to-face, telephone contact) • Duration and frequency of encounters	Percent of people with HIV charts with documented services and encounters.	N: Number people with HIV charts with documented services and encounters. D: Number of case management people with HIV in the measurement year.	Chart review
All case management case note documentation must be written in either Assessment, Plan, Intervention, and Evaluation (APIE) or Subjective, Objective, Assessment, and Plan (SOAP) format case note in accordance with the Georgia RW Part B Case Management SOPs.	Percent of case notes documentation that reflect APIE or SOAP format was utilized in accordance with the Georgia RW Part B Case Management Standards.	N: Number of charts that utilized APIE or SOAP format case note documentation. D: Number of people with HIV charts in the measurement year.	Chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
All entries in the people with HIV record by the case manager should contain the case manager's professional title, signature, and **date of encounter.**	Case management documentation should contain the case manager's professional title, signature, and **date of encounter.**	N: Number of people with HIV charts with documentation reflecting the case manager's professional title, signature, and **date of encounter.** D: Number of people with HIV charts in the measurement year.	Chart review
Obtain assurances and documentation showing that case management staff is operating as part of the clinical care team.	Percent of case managed people with HIV charts that had documentation showing that case management staff is operating as part of the clinical care team.	N: Number of case managed people with HIV charts that had documentation showing that case management staff is operating as part of the clinical care team in the measurement year. D: Number of case managed people with HIV in the measurement year.	Chart review
Provide written assurances and maintain documentation showing that case management services are provided by trained professionals who are either medically credentialed or trained health care staff who are part of the clinical care team.	Review credentials and/or evidence of training of health care staff providing case management services.	N: Number of staff with credentials and/or evidence of training of health care staff providing case management services in the measurement year. D: Number of staff providing case management services in your Ryan White Part B Program within your district in the measurement year.	Chart review
ADAP PERFORMANCE MEASURES			
All ADAP people with HIV must recertify for ADAP annually. Note: Verifying Medicaid status is part of ADAP policy.	ADAP enrollment sites have systems to track ADAP people with HIV recertification due date. Percent of eligible ADAP applicants who successfully recertified according to their recertification due date.	System to track ADAP recertification. N: Number of ADAP people with HIV who are reviewed for continued ADAP eligibility in the measurement period. D: Number of ADAP people with HIV in the measurement period.	Review of ADAP recertification tracking systems. People with HIV record review Custom report from CAREWare. Georgia Health Partnership Portal to verify Medicaid eligibility.

Criteria	Indicators	Data Elements	Data Sources & Methods
Local ADAP enrollment site representatives will submit correctly completed ADAP applications to the state ADAP.	Percent of correctly completed ADAP applications submitted to the state ADAP during the reporting period.	N: Number of correctly completed ADAP applications submitted to ADAP during the reporting period. D: Number of ADAP applications submitted to ADAP during the reporting period.	Custom reports from CAREWare
Initial ADAP applications should be correctly and completely submitted.	Percent of ADAP applications sent back for specified deficiencies.	N: Number of ADAP applications sent back to ADAP enrollment sites for a specified deficiency. D: Number of ADAP applications submitted to state ADAP during the reporting period.	Custom reports from CAREWare
State ADAP will approve or deny people with HIV for ADAP services within two weeks of receiving a complete ADAP application.	Percent of new ADAP applications approved or denied for ADAP enrollment within two weeks of ADAP receiving a complete application during the reporting period.	N: Number of applications that were approved or denied within two weeks of ADAP receiving a complete application during the reporting period. D: Number of complete applications received during the reporting period.	Custom reports from CAREWare
Local ADAP enrollment site representatives must inform the state ADAP when a person with HIV discontinues or terminates ADAP services. People with HIV are discontinued from ADAP services if the person with HIV has not picked-up medications for 60 or more consecutive days and/or if the person with HIV has not recertified.	Local ADAP enrollment sites follow the ADAP "Procedures for Discontinuation." ADAP Discontinuation Forms are completed and sent to ADAP.	Procedures for discontinuation Discontinuation Forms	Review of procedures during site visits. Chart review
People with HIV on ADAP will receive **appropriate** DHHS recommended antiretroviral (ARV) regimens.	Percent of identified ARV regimens or component prescriptions identified as DHHS 'not recommended' and resolved by ADAP during the measurement year.	N: Number of ARV regimens or component prescriptions in the denominator reviewed by ADAP and identified as DHHS 'not recommended'. D: Number of ARV regimens or component prescriptions funded and reviewed by ADAP during the measurement year.	PBM reports – in process. ACP Network On-Site Audits

Criteria	Indicators	Data Elements	Data Sources & Methods
ADAP will conduct an internal audit of new applications quarterly to determine if the applications and recertifications are completed and approved or denied according to ADAP policies and procedures.	Percent of ADAP new application forms that were correctly completed during the quarter.	N: Number of ADAP new applications that were correctly completed during the reporting period. D: Number of ADAP new applications reviewed during the reporting period.	Internal audit of ADAP new applications
CLINICAL PERFORMANCE MEASURES - GENERAL			
People with HIV will receive ongoing risk reduction counseling as part of their medical care.	Percent of people with HIV who received HIV risk counseling within the measurement year.	N: Number of people in the denominator who received HIV risk counseling as part of their medical care. D: Number of people with HIV who had at least one medical visit[1] in the measurement year.	CAREWare CM Chart Review
People with HIV will receive substance use screening during the measurement year.	Percent of people with HIV who have been screened for substance use in the measurement year.	N: Number of people in the denominator who were screened for substance use within the measurement year. D: Number of people with HIV who had at least one medical visit[1] in the measurement year.	CAREWare CM Chart Review
People with HIV will receive behavioral health screening during the measurement year.	Percent of people with HIV who have had a behavioral health screening.	N: Number of people in the denominator who received a behavioral health screening. D: Number of people with HIV who had at least one medical visit[1] in the measurement year.	CAREWare CM Chart Review
CLINICAL PERFORMANCE MEASURES – ORAL HEALTH EXAMS			
People with HIV will receive an oral examination by a dentist at least annually.	1) Percent of people with HIV who received an oral examination by a dentist at least once in the measurement year.	1) N: Number of people in the denominator who had an oral exam by an oral health provider in the measurement year. D: Number of people with HIV who had at least one medical visit[1] in the measurement year.	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
CLINICAL PERFORMANCE MEASURES – MEDICAL VISITS			
Gap in HIV medical visits - Percent of people with HIV, who did not have a medical visit in the last 6-months of the measurement year.	Percent[2] of people with HIV who did not have a medical visit in the last 6-months of the measurement year.	1) N: Number of people in the denominator who did not have a medical visit in the last 6-months of the measurement year. D: Number of people with HIV who had at least one medical visit[1] in the first 6-months of the measurement year. 2) N: Number of people in the denominator who did not have a medical visit in the last 6-months of the measurement year. D: Number of people with HIV who had at least one medical visit[5] in the first 6-months of the measurement year, excluding those with documentation of no longer receiving care (i.e., deceased, transferred, lost to follow-up, etc.) at any time during the measurement year.	CAREWare Clinical chart review
HIV Medical visit frequency - Percent of people with HIV, who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.	Percent[2] of people with HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.	1) N: Number of people in the denominator who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period. D: Number of people with HIV who had at least one medical visit[1] in the first 6-months of the 24-month measurement period, excluding those who died at any time during the 24-month measurement period.	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
		2) N: Number of people in the denominator who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit[5] in the subsequent 6-month period. D: Number of people with HIV who had at least one medical visit in the first 6-months of the 24-month measurement period, excluding those with documentation of no longer receiving care (i.e., deceased, transferred, lost to follow-up, etc.) at any time during the measurement period.	Clinical chart Review
CLINICAL PERFORMANCE MEASURES – HIV VIRAL LOADS			
People with HIV should have viral load repeated every 3-4 months or as clinically indicated to confirm continuous viral suppression. Clinicians may extend the interval to six months for adherent, stable people with HIV whose viral load have been suppressed for more than two years.	Percent[2] of people with HIV, with a viral load test performed at least every six months during the measurement year.	N: Number of people in the denominator with a viral load test performed every six months. D: Number of people with HIV who had at least one medical visit[5] in the measurement year excluding those with documentation of no longer receiving care (i.e., deceased, transferred, lost to follow-up, etc.) at any time during the measurement year.	Clinical chart review
Viral load suppression - Percent of people with HIV, with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	Percent[2] of people with HIV, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	N: Number of people in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. D: Number of people with HIV who had at least one medical visit[1,5] in the measurement year.	CAREWare Clinical chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
CLINICAL PERFORMANCE MEASURES – ANTIRETROVIRAL THERAPY			
Resistance testing before the initiation or re-initiation of ART.	Percent[2] of people with HIV (first visit within the review year) who had resistance testing performed before the initiation or re-initiation of ART.	N: Number of people in the denominator in which resistance testing was performed before the initiation or re-initiation of ART. D: Number of individuals with HIV **who had at least one medical visit[5] in the measurement year** and **initiated or re-initiated** ART.	Clinical chart review
Prescription of ART - Percent of people with HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year.	Percent[2] of people with HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year.	N: Number of people in the denominator prescribed HIV antiretroviral therapy during the measurement year. D: Number of people with HIV, who had at least one medical visit[1,5] in the measurement year.	CAREWare Clinical chart review
People with HIV will receive appropriate ART based on current DHHS guidelines.	Percent[2] of people with HIV on ART according to DHHS antiretroviral treatment guidelines in the measurement year.	N: Number of people in the denominator on ART according to DHHS guidelines in the measurement year. D: Number of people with HIV on ART and who had at least one medical visit[5] in the measurement year.	Clinical chart review
All pregnant **clients** with HIV should receive ART, to prevent perinatal transmission as early in pregnancy as possible.	Percent[2] of pregnant **clients** with HIV who were prescribed ART.	N: Number of pregnant **clients** in the denominator who were prescribed ART. D: Number of pregnant **clients** with HIV who had at least one medical visit[1,5] in the measurement year.	CAREWare Clinical chart review
People with HIV will have lipid profile evaluated at least annually.	Percent[2] of people with HIV who had a random or fasting lipid profile completed in the measurement year.	N: Number of people in the denominator who had a lipid profile completed in the measurement year. D: Number of people with HIV on ART who had at least one medical visit[1,5] in the measurement year.	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
CLINICAL PERFORMANCE MEASURES – CERVICAL CANCER SCREENING AND SEXUALLY TRANSMITTED INFECTION (STI) SCREENING			
Clients with HIV should begin cervical cancer screening at 21 years of age.	1) Percent of females with HIV who were screened for cervical cancer in the last three years. 2) Percent[2] of **clients** with HIV who received **a pap smear** per DHHS guidelines.	1) N: Number of females in the denominator who were screened for cervical cancer in the last three years. D: Number of females with HIV 21 years or older who had at least one medical visit[1] in the measurement year (excludes people with HIV with hysterectomy). 2) N: Number of **clients** in the denominator who **received a pap smear** per DHHS guidelines. D: Number of **clients** with HIV, who had at least one medical visit[5] in the measurement year **indicated for pap smear screening per DHHS guidelines**.	CAREWare Clinical chart review
All **clients** with HIV with abnormal cervical cancer screening results will have documented follow-up as per DHHS guidelines.	Percent[2] of clients with HIV with abnormal cervical cancer screening results having documented follow-up as per DHHS guidelines.	N: Number of **clients** in the denominator with abnormal cervical cancer screening results and documented follow-up as per DHHS guidelines. D: Number of **clients** with HIV with abnormal cervical cancer screening results who had at least one medical visit[5] in the measurement year. (excludes **client** with hysterectomy for benign reason).	Clinical chart review
People with HIV at risk for an STI will be screened for chlamydia at least annually.	Percent of people with HIV who had a test for chlamydia within the measurement year.	N: Number of people in the denominator who had a test for chlamydia. D: Number of people with HIV, 18 years of age or older, who had at least one medical visit[1] in the measurement year.	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
People with HIV at risk for an STI will be screened for gonorrhea at least annually.	Percent of people with HIV who had a test for gonorrhea within the measurement year.	N: Number of people in the denominator who had a test for gonorrhea. D: Number of people with HIV, 18 years of age or older, who had at least one medical visit[1] in the measurement year.	CAREWare
People with HIV will be screened for syphilis at least annually.	Percent[2] of people with HIV who were screened for syphilis in the measurement year.	N: Number of people in the denominator who had a serologic test for syphilis performed in the measurement year. D: Number of people with HIV, 18 years of age or older, who had at least one medical visit[1,5] in the measurement year.	CAREWare Clinical chart review
CLINICAL PERFORMANCE MEASURES – TUBERCULOSIS AND HEPATITIS SCREENING			
People with HIV without a history of previous tuberculosis (TB) treatment, positive TB skin (TST) test or positive Interferon-Gamma Release Assay (IGRA) will be screened for TB.	1) Percent of people with HIV with documentation of TB screening test performed at least once since the diagnosis of HIV infection.	1) N: Number of people in the denominator who had documentation that a TB screening test was performed at least once since diagnosis of HIV infection. D: Number of people with HIV who had at least one medical visit[1] in the measurement year.	CAREWare
All people with HIV will be screened for Hepatitis B infection status.	Percent of people with HIV, for whom Hepatitis B screening was performed .	N: Number of people in the denominator for whom Hepatitis B screening was performed. D: Number of people with HIV who had at least one medical visit[1] in the measurement year.	CAREWare
All people with HIV will be screened for Hepatitis A infection status.	Percent of people with HIV for whom Hepatitis A screening was performed or for whom there is documented infection or immunity.	N: Number of people in the denominator for whom Hepatitis A screening was performed. D: Number of people with HIV who had at least one medical visit[1] in the measurement year.	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
All people with HIV will be screened for Hepatitis C virus (HCV) at least once after HIV diagnosis, and more frequently if indicated.	Percent[2] of people with HIV for whom HCV screening was performed at least once since HIV diagnosis.	N: Number of people in the denominator with documentation of HCV status. D: Number of people with HIV who had at least one medical visit[1,5] in the measurement year.	CAREWare Clinical chart review
CLINICAL PERFORMANCE MEASURES – HEPATITIS, INFLUENZA AND PNEUMOCOCCAL VACCINATIONS			
All people with HIV who do not have evidence of Hepatitis B (HBV) virus infection, past immunity, valid contraindications, or reasons to defer, should receive the HBV vaccination series followed by assessment of antibody response.	1) Percent of people with HIV who completed the vaccination series for Hepatitis B. 2) Percent[2] of people with HIV who completed the vaccination series and antibody assessment for Hepatitis B according to DHHS Guidelines	1) N: Number of people in the denominator with documentation of having ever completed the vaccination series for Hepatitis B. D: Number of people with HIV who had a medical visit[1] at least once in the measurement year. 2) N: Number of people in the denominator with documentation of having completed the vaccination series and antibody assessment for Hepatitis B per DHHS Guidelines. D: Number of HBV susceptible people with HIV who had a medical visit[5] at least once in the measurement year, excluding those with HIV newly enrolled during the measurement year, or with valid contraindications.	CAREWare Clinical chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
All people with HIV who do not have evidence of Hepatitis A (HAV) virus infection, past immunity, valid contraindications, or reasons to defer, should receive the HAV vaccination series followed by assessment of antibody response.	1) Percent of people with HIV who completed the vaccination series for Hepatitis A. 2) Percent[2] of people with HIV who completed the vaccination series and antibody assessment for Hepatitis A according to DHHS Guidelines	1) N: Number of people in the denominator with documentation of having completed the vaccination series for Hepatitis A. D: Number of people with HIV who had a medical visit[1] at least once in the measurement year. 2) N: Number of people in the denominator with documentation of having completed the vaccination series and antibody assessment for Hepatitis A per DHHS Guidelines. D: Number of HAV susceptible people with HIV who had a medical visit[5] at least once in the measurement year, excluding those with HIV newly enrolled during the measurement year, or with valid contraindications.	CAREWare Clinical chart review
All people with HIV without valid contraindications should receive the influenza vaccine annually.	Percent[2] of people with HIV who received influenza vaccination within the measurement period.	1) N: Number of people in the denominator who received influenza vaccination during the current measurement period (8/1 to 9/30; 8/1 to 12/30; 8/1 to 3/31; 8/1 to 6/30). D: Number of people with HIV who had a medical visit[1] during the current measurement period (8/1 to 9/30; 8/1 to 12/30; 8/1 to 3/31; 8/1 to 6/30). 2) N: Number of people in the denominator with documentation of receipt of influenza vaccination in the flu season measured. D: Number of people with HIV who had a medical visit5 in the measurement year, excluding those whose first visit was outside of the flu season measured or with documentation of valid contraindications.	CAREWare Clinical chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
All people with HIV without valid contraindications, should receive the pneumococcal vaccine.	Percent of people with HIV who have received pneumococcal vaccines (PCV13, **PCV15, PCV 20** and PPSV23).	N: Number of people in the denominator who have received pneumococcal vaccines (PCV13, **PCV15, PCV20,** and PPSV23). D: Number of people with HIV who had a medical visit[1] at least once in the measurement year.	CAREWare
CLINICAL PERFORMANCE MEASURES – OPPORTUNISTIC INFECTION PROPHYLAXIS			
Most people with HIV with CD4 counts less than 200 cells/mm^3 should receive chemoprophylaxis against *Pneumocystis* pneumonia (PCP).	Percent[2] of people with HIV who were prescribed PCP prophylaxis.	1) N: Number of people in the denominator who were prescribed PCP prophylaxis. D: Number of people with HIV with CD4 counts below 200 cells/mm^3 who had at least one medical visit[1] in the measurement year. who had at least one medical visit[5] in the measurement year, excluding those who were not indicated for prophylaxis per DHHS guidelines. 2) N: Number of people in the denominator with CD4 counts below 200 cells/mm^3 who were prescribed PCP prophylaxis. D: Number of people with HIV with CD4 counts below 200 cells/mm^3 who had at least one medical visit[5] in the measurement year, excluding those who were not indicated for prophylaxis per DHHS guidelines.	CAREWare Clinical chart review

[1]CAREWare - Outpatient/Ambulatory Medical Care visits include i.e., primary care, lab, medication pick up.
[2]Clinical chart review percent is weighted average.
[4]People with HIV self-report not accepted.
[5]Clinical chart review - medical visit with a prescribing provider before November 1st of measurement year.

APPENDIX F

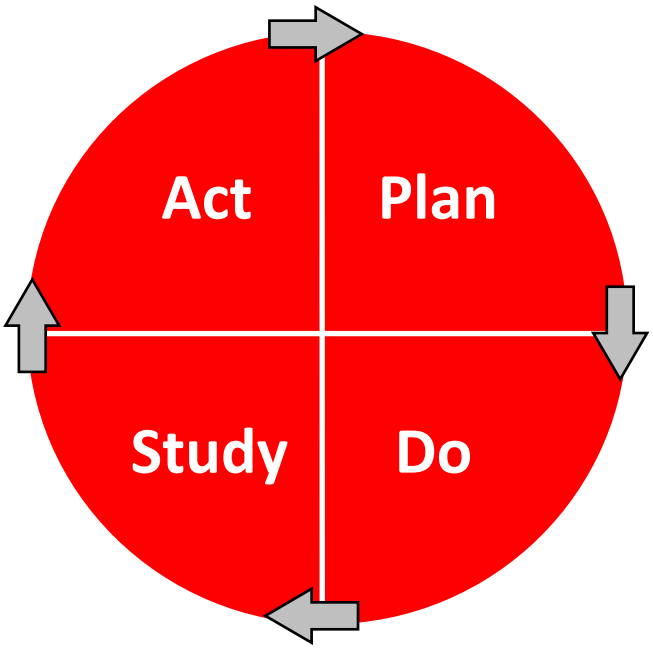
CONTINUOUS QUALITY IMPROVEMENT METHODOLOGY

CQI METHODOLOGY

MODEL FOR IMPROVEMENT

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

PLAN-DO-STUDY-ACT



ACT • What changes are to be made? • Next cycle? • Adapt, Adopt, Abandon?	**PLAN** • Objective • Questions and predictions (why) • Plan to carry out the cycle (who, what, where, when)
STUDY • Complete the analysis of the data • Compare data to predictions • Summarize what was learned	**DO (Small Scale)** • Carry out the plan • Document problems and unexpected observations • Begin analysis of the data

PLAN-DO-STUDY-ACT

Date: Cycle Number: Began: Completed: Team:

PLAN (*fill out before the test/cycle*)

What is the purpose of this cycle?

Details: Who, What, Where, When, How

What do we expect (predict) will be the effect or outcome of the change?

If our expectation (prediction) is on target, what will be our next test/cycle or action?

DO and STUDY (fill out during and after the test/cycle)

Was the test/cycle carried out as we planned? Yes No If no, why not?

What did we observe that was not part of our plan?

How did we study and understand the result?

How did or didn't the outcome of this test/cycle agree with our expectation (prediction)?

What did we learn from this test/cycle?

ACT: (fill out after the test/cycle is completed)

Given the above understanding and learning, what are we going to do now?

Are there forces in our organization that will help or hinder these changes?

Source: The HAB/ National Quality Center (NQC) Ryan White Part B Program Collaborative

APPENDIX G

CLINICAL QUALITY MANAGEMENT PLAN APPROVAL

GEORGIA
RYAN WHITE PART B
FY2023-2024
CLINICAL QUALITY MANAGEMENT
PLAN APPROVAL

The FY2023-2024 CQM Plan and Work Plan are approved by the following:

Sandra Metcalf _____ 3/22/2023

Sandra Metcalf, MPH, RN, ACRN — Date
on behalf of Georgia Ryan White Part B CQM Core Team

Marisol Cruz _____ 3/23/2023

Marisol Cruz, DBA, MS - HIV Care Manager — Date
Georgia Department of Public Health

Alexander Millman Digitally signed by Alexander Millman Date: 2023.04.04 07:43:46 -04'00' _____

Alexander Millman, MD – Chief Medical Officer — Date
Georgia Department of Public Health

DPH
GEORGIA DEPARTMENT OF PUBLIC HEALTH