Georgia

Ryan White Part B

Clinical Quality Management Plan

April 1, 2018 – March 31, 2019

Georgia Department of Public Health
Division of Health Protection
Office of HIV/AIDS

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I. Introduction

About this Document

Ryan White HIV/AIDS legislation requires clinical quality management (QM) programs as a condition of grant awards. The QM expectations for Ryan White (RW) Program Part B recipients include: 1) Assist direct service medical providers funded through the CARE 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 Program Part B Clinical QM Plan is outlined in this document. This document is considered a "living" document and the Georgia Department of Public Health (DPH), Division of Health Protection, Office of HIV/AIDS will continue to develop and expand the RW Program Part B Clinical QM Program and plan. This Plan is effective April 1, 2018 to March 31, 2019**.** 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 Program Part B Clinical QM Team: Sandra Metcalf (404) 657-3113 or Pamela Phillips (404) 657-8993.

Ryan White Overview

The Ryan White Comprehensive AIDS Resources Emergency Act is a Federal legislation that addresses the unmet health needs of persons living with HIV/AIDS (PLWHA) 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 $2.32 billion in 2017.

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

Federal funds are awarded to agencies located around the country, which in turn deliver care to eligible individuals under funding categories called Parts.

- **Part A** provides emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV/AIDS epidemic.
- **Part B** provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five (5) U.S. Pacific Territories or Associated Jurisdictions.
- **Part C** provides comprehensive primary health care in an outpatient setting for people living with HIV disease.
- **Part D** provides family-centered care involving outpatient or ambulatory care for women, infants, children, and youth with HIV/AIDS.
- **Part F** provides funds for a variety of programs:
    - **The Special Projects of National Significance Program** grants fund innovative models of care and supports the development of effective delivery systems for HIV care.

- **The AIDS Education and Training Centers Program** supports a network of 11 regional centers and several National centers that conduct targeted, multidisciplinary education and training programs for health care providers treating people living with HIV/AIDS.
- **Dental Programs** provide additional funding for oral health care for people with HIV.
- **The Minority AIDS Initiative** provides funding to evaluate and address the disproportionate impact of HIV/AIDS among African Americans and other minorities.

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.

Sub-recipients are encouraged to assess the outcomes of their programs along the HIV Care Continuum. Funded agencies 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.

II. Quality Statement

A. Mission

The mission of the RW Program Part B Clinical Quality Management Program is to ensure the highest quality of medical care and supportive services for people living with HIV/AIDS (PLWHA) in Georgia.

B. Vision

The vision of the Clinical QM 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 living with HIV/AIDS in Georgia. This will be accomplished by:

- Assessing the extent to which HIV health services provided to clients 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 the application and recertification processing.
- Improving alignment across funded agencies by monitoring core performance measures across RW Program Part B funded agencies.

- Improving alignment across services through standardization of case management.
- Improving alignment across RW Programs by expanding quality related collaboration.

III. Organizational Infrastructure

In Georgia, the Ryan White Part B Program is administered by the Georgia Department of Public Health (DPH), Division of Health Protection, Office of HIV/AIDS. The Office of HIV/AIDS funds agencies in 16 public health districts to deliver HIV/AIDS services throughout the state. The agencies are responsible for planning and prioritizing the delivery of HIV services in their respective geographic areas. All funded agencies provide primary care services. Support services are funded based on the availability of resources. Part B also funds the Georgia ADAP and HICP, which provide medications and health insurance coverage.

The primary role of sub-recipients, also referred to as funded agencies, is to provide medical and support services to all eligible persons living with HIV/AIDS who reside in Georgia. Sub-recipients 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 individuals with HIV/AIDS (emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, sexually transmitted disease (STD) clinics, and others) for the purpose of facilitating early intervention for individuals newly diagnosed with HIV/AIDS 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.

A. Leadership and Accountability

1. Georgia Department of Public Health

The State of Georgia through the Department of Public Health (DPH) is the recipient of the Ryan White Program Part B grant. The DPH administers the grant through the Division of Health Protection, Office of HIV/AIDS.

2. Office of HIV/AIDS

The Office of HIV/AIDS provides oversight and management of the RW Program Part B 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 Clinical QM Plan. The HIV Care Manager is responsible for ensuring administration of the grant, including the development and implementation of the Clinical QM Plan.

3. 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.

4. Ryan White (RW) Program Part B Funded Agencies

RW Program Part B funded agencies are responsible for ensuring quality management components of the Grant-in-Aid and contractual agreements are met. The FY2018-2019 QM deliverables include the following language, as referenced in the Georgia RW Program Part B/ADAP/HICP Policies and Procedures:

- Funded agencies are expected to refer to the Georgia Ryan White Program Part B CQM Plan which contains goals, objectives and strategies to ensure the implementation and monitoring of quality management activities, as well as compliance with HRSA's CQM expectations at both the state and local levels. Office of HIV/AIDS Ryan White Part B Program activities are delineated in the plan, including capacity building and providing quality-related technical assistance to funded health agencies. The statewide CQM Core Team provides oversight and facilitation of the plan and is composed of multidisciplinary professionals, with representation from each funded agency, including agency staff and/or consumers.
- Funded agencies 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.
    - Ensure compliance with the Georgia Department of Public Health (DPH), Office of HIV/AIDS manual, Georgia Ryan White Part B Clinic Personnel Guidelines (current edition).
    - Ensure that registered professional nurses (RN), nurse practitioners (NP), and physician assistants (PA) 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, Section 10. HIV-Infected Adult
        - Georgia Department of Public Health, Guidelines for Public Health APRN Prescriptive Authority
        - Georgia Department of Public Health Policy #PT-18001, Georgia ADAP APRN Prescriptive Authority for APRNs Not Employed by Public Health Policy and Procedure (current edition.
        - Georgia Department of Public Health Policy #PT-18002, Georgia ADAP Physician Assistant Provider Status Policy and Procedure (current edition).
    - Compliance with United States Department of Health and Human Services (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 online at the AIDSinfo website http://aidsinfo.nih.gov/
    - 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 Clinical QM Program according to HRSA's HIV/AIDS Bureau (HAB) expectations for Ryan White recipients. Include the following:
  - A written QM Plan, which is updated annually
  - Project-specific continuous quality improvement (CQI) plan (e.g., work plan)
  - A leader and team to oversee the Clinical QM Program.
  - QM goals, objectives, and strategies.
  - Performance measures and mechanisms to collect data.
  - Communication of results to all levels of the organization, including consumers as appropriate.
- Participate in the statewide Part B Clinical QM Program.
- Monitor performance measures as determined by the Part B Clinical QM Program.
- Participate in HIV clinical and case management chart reviews conducted by Office of HIV/AIDS QM staff.
- Provide QM Plans, reports (to include Quality Improvement activities), and other information related to the local QM Program as requested by the Office of HIV/AIDS Ryan White Part B District Liaison and/or QM staff. Allow the District Liaison and/or QM staff access to all QM information and documentation.
- Ensure compliance with the Georgia HIV/AIDS Case Management Standards (current edition). Including the following:
  - Case managers utilize the standardized case management client intake form or an equivalent for agencies using electronic medical records (EMRs).
  - Clients receiving any medical or non-medical Part B funded service must be enrolled in Case Management.
  - All new and re-enrolling case managed clients must have an Intake, Acuity Scale, Individualized Service Plan (ISP) and case note completed within 15-30 days of intake.
  - ISPs must be completed for every new and re-certifying client at least every 6 months.
    - If an ADAP/HICP client already has a case manager, the same ISP can be utilized for the ADAP/HICP client charts.
  - The ISP and case note documentation should reflect how healthcare outcomes are being improved and/or by providing guidance and assistance in improving access to needed services for client.

B. Clinical Quality Management Committee(s)

1. Quality Management Core Team

a. Purpose

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

b. Membership

- The Core Team membership will be reviewed annually and changes made accordingly.
- Each RW Program Part B funded agency must identify one person and an alternate to represent their district. The person identified will become an active member of the QM Core Team and the alternate will be available to serve on the team only if the team member cannot attend. (See Appendix C for committee members.)
- Membership by consumers is voluntary. There will be two female and two male members for the entire QM Core Team. This consumer will not be representing a particular district but rather will be representing consumers who have access to RW Program Part B funds and services. Consumers will be chosen as the names are submitted.
- Persons interested in volunteering will submit requests to the Office of HIV/AIDS or Core Team.
- Composition and Roles/Responsibilities

The Core Team will include the following members:

Senior Office of HIV/AIDS Leadership: Any or all of the positions below, or their designees, may attend meetings to represent the involvement of senior leadership.

Office of HIV/AIDS Staff

- The Office of HIV/AIDS Director – Duties include: Office of HIV/AIDS leadership and coordination of HIV care and prevention activities.
- The HIV Care Program Manager – Duties include: Responsible for grant oversight and management, allocation of resources, and ensuring the development and implementation of the QM plan, including systems-level CQI projects.
- Assistant HIV Care Program Manager – Duties include: Assists with grant oversight and management, supervises District Liaison Team, responsible for ensuring the development and implementation of appropriate 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 QM requirements
- Ensure QM/QI 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

- Nurse Consultant (QM Team Leader). Duties include:
  - Supervise the QM Team
  - Coordinate day-to-day Clinical QM Program operations and meetings
  - Coordinate systems-level CQI projects
  - Ensure development, implementation, and evaluation, of the QM Plan and Work Plan
  - Ensure revision of the QM Plan at least annually, and the Work Plan at least quarterly
  - Oversee the submission of required reports related to QM to upper management
  - Coordinate and ensure QM/QI and other HIV-related training is available
  - Closely monitor assigned funded agencies' QM plans and quarterly reports
  - Oversee technical assistance provision to RW Program Part B funded agencies by staff (i.e. development of local QM plans, nursing/clinical services and case management
  - Coordinate site visits to review QM plans and activities and/or to review clinical performance indicators
  - Participate on the DPH Nursing QA/QI Team
  - Participate in GA Ryan White Programs quality-related committees and activities
  - Participate in revision of the HIV/AIDS-related nurse protocols
  - Develop and revise HIV-related medical guidelines and other guidelines/polices as indicated
  - Attend Metro Atlanta EMA Planning Council and 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/or Quality Management
- Nurse Consultant - Duties include:
  - Assist with coordination of day-to-day operations of the Clinical QM 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 QM Core Team
- Closely monitor assigned funded agencies' QM plans and quarterly reports
- Provide technical assistance to RW Program Part B funded agencies in the development of local QM plans and activities
- Conduct site visits to review QM plans and activities, adherence activities, or clinical performance indicators
- Coordinate revisions of nurse protocols
- Develop or revise medical guidelines, polices, and/or procedures
- Attend Metro Atlanta EMA Quality Management Committee meetings
- Participate in GA Ryan White Programs quality-related committees and activities
- 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 Quality Management

• QM Coordinator - Duties include:
  - Assist with coordination of day-to-day operations of the Clinical QM Program:
    - Plan meetings and/or conference calls
    - Communicate with the Core Team and subcommittees
    - Complete reports and other assignments
    - Facilitate the Case Management Subcommittee
    - Participate in systems-level CQI projects
  - Participate on the QM Core Team
  - Ensure development, implementation, and evaluation of statewide case management standards and tools
  - Ensure QM/QI and case management training is available
  - Assist with revision of the QM Plan and Work Plan
  - Closely monitor assigned funded agencies' QM plans and quarterly reports
  - Provide technical assistance to the RW Program Part B funded agencies in the development of local QM plans and activities
  - Conduct site visits to review QM plans and activities, and/or to review case management services
  - Participate in GA Ryan White Programs quality-related committees and activities
  - Attend Metro Atlanta EMA Planning Council and 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/or Quality Management
• Medical Advisor Section IDI/HIV - Duties include:

  - Participate on the QM Core Team
  - Provide medical expertise and technical assistance to the Office of HIV/AIDS, ADAP, RW Program Part B funded agencies and others
  - Chair the HIV Medical Advisory Committee (HIV-MAC).
  - Conduct site visits to review clinical performance measures including: management and utilization of antiretroviral therapy
  - Revise and approve the HIV/AIDS-related nurse protocols
  - Provide training to HIV providers and others as indicated
  - Mentor physicians inexperienced in HIV care
  - Assist with QM-related reports and assignments
  - Assist with development and/or revisions of medical guidelines, polices, and/or procedures
- QM Data Manager – Duties include:
  - Collaborate with the HIV Epidemiology Section and RW Statistical Analyst to facilitate optimal use of available data for QM activities
  - Design procedures for the collection/evaluation of data
  - Provide data-related technical assistance
  - Analyze data
  - Assist with the data component of quality reports. Create reports, graphs, charts, and spreadsheets to summarize and explain data
- The AIDS Drug Assistance Program (ADAP)/Healthcare Insurance Continuation Program (HICP) Manager – Duties include:
  - Manage and coordinate ADAP/HICP and all related components of the QM plan including CQI projects and performance measures
  - Facilitate the ADAP/HICP Workgroup
  - Ensure QM/QI 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 Quality Management
- ADAP Pharmacy Director – Duties include:
  - Train ADAP Contract Pharmacy (ACP) Network personnel
  - Monitor ADAP contract pharmacies
  - Oversight and monitoring of ADAP contract pharmacy on-site audits and visits to review contract compliance including antiretroviral therapy management and dispensing
  - Medication-related system improvements of ADAP including the contracted pharmacies
  - Provide pharmacy expertise and TA to the Office of HIV/AIDS, ADAP, Part B funded agencies and others
  - Participate on the HIV Medical Advisory Committee
  - Participate in the revision of the HIV/AIDS-related nurse protocols
  - Ensure QM/QI 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 Quality Management

- RW Database Manager – Duties include:
  - Maintain CAREWare database
  - Provide TA and training to state and district staff
  - Create custom reports to collect performance measure data.
  - Generate CAREWare reports
  - Delegate duties to CAREWare staff as needed

Other QM Core Team Members

- Peer Advocates/Consumers – Duties include:
  - Represent the client's perspective on ways to improve quality of services
  - Suggest quality improvement process and projects
  - Provide direct feedback on services and barriers including:
    - Needs assessments
    - Satisfaction surveys
    - Interviews
- Representative from HIV/AIDS Surveillance (Ad hoc) – Duties include:
  - Provide HIV and AIDS case reporting data for planning and quality improvement opportunities as needed
- Ryan White Program Part B funded agencies (District HIV Coordinator) – Duties include:
  - Agency/program Representative
  - Suggest quality improvement processes and projects
  - Provide direct feedback on services and barriers
  - Ensure that RW Part B QM activities align with his/her local QM plan/activities
- Representatives from RW Program Parts A, C, and D – Duties include:
  - Represent their agencies/programs and ensure that Part B QM activities align across RW Programs statewide
- Medicaid Representative (Ad hoc) – Duties include:
  - Assist with Medicaid-related QM activities as needed
- Representative from HIV Prevention – Duties include:
  - Provide updates on HIV Prevention activities and coordinate activities when possible
- Representative from Fetal Infant Mortality Registry (Perinatal Coordinator)/HIV Program – Duties include:
  - Provide updates on progress of program implementation and share aggregate data as indicated
- All other RW Program Part B Office of HIV/AIDS staff – Duties include:

- Participate in activities of the QM Plan as needed. (See Appendix C for 2018-2019 Core Team Members)

c. Communication

- The Core Team meets at least once quarterly. In-person meetings are preferred.
- Additional conference calls and electronic communication is ongoing, as needed.
- The Core Team shares QM/QI findings/reports within DPH; with the Office of HIV/AIDS, RW Program Part B funded agencies, and others.
- District Liaisons ensure QM/QI findings/reports are shared at consortia meetings.

d. General Core Team Responsibilities

- A Nurse Consultant serves as the key contact and team leader for quality management.
- At least one member of the QM Core Team routinely attends the Metro Atlanta EMA Planning Council and Part A Quality Management Committee meetings.
- The Core Team is responsible for guiding the overall Clinical QM 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 Program Part B funded agencies/consortia, DPH leadership and others
  - Reviews and updates the QM Plan annually
  - Makes recommendations to the Office of HIV/AIDS for appropriate education related to QI topics
  - Conducts evaluation activities

2. Subcommittees

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

a. Case Management Subcommittee

- **Goal**: The committee identifies gaps in service provision, sets priorities for system expansion, discusses case manager training needs, and develops strategies to address client issues.
- **Membership**: Sub-Committee members may differ from the QM Core Team members. Each funded agency has identified a person to represent their district. (See Appendix C for committee members).

- Membership by consumers is voluntary. There will be one female and one male member for the entire Subcommittee. The consumer does not represent a particular district, but rather represents consumers who have access to RW Program Part B services. Consumers are selected as needed following submission of candidates.

- **Responsibilities**:
  - Comply with the Core Team's overall goals and Work Plan
  - Communicate with the Core Team
  - Submit meeting minutes in predetermined format
  - Monitor Ryan White Program Part B Case Management (CM) standards

b. Georgia ADAP/HICP Quality Management Subcommittee

- **Goal**: Improve access to ADAP and HICP services.
- **Membership**: Will consist of 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 committed 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 Core Team
  - Submit meeting minutes in predetermined format
  - Monitor ADAP/HICP policy, processes, and progress from a quality management viewpoint
  - Identify ADAP/HICP problems/issues and make recommendations for improvement

3. Office of HIV/AIDS HIV Care Team

a. Goal: Plan, implement, monitor and evaluate quality, including CQI projects, to improve HIV care systems.

b. The HIV Care Team includes: the HIV Nurse Consultant Team Lead, HIV Nurse Consultant(s), QM Coordinator, HIV Care Manager, ADAP/HICP Manager, ADAP Pharmacy Director, ADAP and HICP staff, District Liaisons, CAREWare Team Leader, QM Data Manager and staff.

c. Responsibilities:
  - Develop, implement, monitor and evaluate the QM Plan
  - Identify areas for improvement projects
  - Conduct and evaluate improvement projects
  - Document improvement projects and results
  - Utilize CQI methodologies such as PDSA (Plan, Do, Study, Act) cycles for small tests of change
  - Report back to QM Core Team as appropriate
  - Systematize changes if appropriate

4. Local Funded Agencies and QM Committees

a. Each funded agency is required to convene and maintain a local HIV-specific QM committee.
b. 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.
c. Local QM committees should meet at least quarterly and guide HIV care related QM activities.
d. The local QM committee is responsible for developing, implementing, monitoring and evaluating the local QM plan.

C. Coordination with Other Statewide QI/QA Activities

1. Coordination across RW Programs

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

2. Coordination within DPH

a. HIV Nurse Consultants participate on the DPH Nursing QA/QI Team led by the Office of Nursing.
b. QM staff collaborates with the Office of Performance Improvement.
c. The Core Team includes an ad hoc member of the HIV/AIDS Surveillance Unit.
d. HIV Prevention Representative and Perinatal Coordinator/HIV representative attend Core Team meetings. The Core Team collaborates on strategies to reduce perinatal HIV transmission in Georgia.
e. At least one member of the Core Team will participate on the Georgia Oral Health Coalition.
f. The Core Team will collaborate with other sections and share quality findings within DPH as indicated.

3. Coordination with ADAP/HICP

a. The overall RW Program Part B Clinical QM Plan includes goals specific to ADAP/HICP. The ADAP/HICP Manager and ADAP Pharmacy Director are members of the Core Team.
b. The GA ADAP/HICP QM Workgroup meets as a subcommittee as needed and reports to the QM Core Team.

4. Feedback from Key Stakeholders

a. The Core Team communicates findings and solicits feedback from both internal and external key stakeholders on an ongoing basis.

b. Presentations are made during RW Program Part B Coordinators meetings, consortia meetings, RW Program meetings, and others as identified.
c. Written reports are shared with key stakeholders.
d. Stakeholders are given the opportunity to provide feedback to reports and to prioritize quality activities.
e. The Office of HIV/AIDS maintains current Part B Clinical QM Plans, reports, and other related information on the Office's web pages.
f. Georgia's 2017-2021 HIV Prevention and Care Plan (which includes the Statewide Coordinated Statement of Need (SCSN)) 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.

D. Capacity Building

- Ryan White Program Part B QM staff participates in Center for Quality Improvement and Innovation (CQII) trainings and webinars to support their ongoing QM skills development. This enables staff to provide and coordinate technical assistance/training for RW Program Part B funded agencies.
- CQII training materials and resources are utilized as much as possible.
- QM technical assistance/training needs are assessed through requests in funded agencies applications, monitoring of local QM plans/programs and quarterly reports, and through training evaluations and/or needs assessments.
- CQI Best Practices. Funded agencies will be selected to showcase best practices and/or success with improvement projects.

IV. Evaluation

A. Self-Assessment

- The QM Core Team completes the *Collaborative Ryan White Program Part B QM Assessment Tool* at least annually.
- The QM plan is assessed using the *Checklist for the Review of an HIV-Specific Quality Management Plan*, assessment tool developed by the National Quality Center (NQC).
- The QM Core Team completes an annual assessment and subsequent revision of the QM plan.
- The QM Core Team evaluates the RW Program Part B Clinical QM Program on an annual basis including rating the completeness of strategies.

B. Evaluation of Local QM Plans

- QM staff members annually review local QM plans including work plans, CQI activities, progress on case management standards and performance indicators. They provide feedback regarding each plan.

C. External Evaluation

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

D. QM Plan Evaluation

- The QM plan includes a timeline to ensure annual revision of the QM plan.
- The timeline incorporates development, implementation, and revision of the plan based on the Ryan White Program Part B grant year. The timeline includes quarterly QM Core Team meetings and progress reports (See Appendix B.)

E. DPH Evaluation

- **At least annually, findings are reported to leadership within DPH.**
- A revised QM plan is submitted to Office of HIV/AIDS leadership for approval on an annual basis.

F. Resources

- Human Resources and Services Administration (HRSA)HIV/AIDS Bureau (HAB) - https://hab.hrsa.gov/
- Center for Quality Improvement & Innovation (CQII) - https://careacttarget.org/cqii
- The Metro Atlanta EMA Ryan White Part A Quality Management Committee - http://www.ryanwhiteatl.org/
- Georgia AIDS Education & Training Center (Georgia AETC) - http://www.msm.edu/Research/research_centersandinstitutes/ga-aetc.php
- HIV/AIDS Epidemiology Unit - https://dph.georgia.gov/georgias-hivaids-epidemiology-surveillance-section
- Ryan White Part B Service Standards
- Ryan White Programs Part C and D
- Other DPH personnel as needed
- Local funded agencies
- National HIV/AIDS Strategy for the United States: Updated to 2020

V. 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 Strategy primary goals:

- Reduce new HIV infections;
- Increase access to care and optimize health outcomes for people living with HIV (PLWH);

- Reduce HIV-related health disparities and health inequities; and
- Achieve a more coordinated national response to the HIV epidemic.

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 Strategy goals. The Quality Management Core Team establishes annual Core Performance Measure goals and collaborates on steps to measure and accomplish these goals. The table below depicts calendar year 2018 goals for HAB Core Performance Measures, definitions and previous year's outcomes. Further details on data collection are in the sections to follow.

Georgia Ryan White Part B Care Program				
Performance Measure	**Goal**	**Outcomes**		
		Dec 2016	**Dec 2017**	**2018**
HIV Viral Load Suppression	83% of Ryan White Part B program participants will have a HIV viral load (VL) less than 200 copies/mL at last HIV VL test during the measurement year.	80%	80%	
	Numerator: Number of participants 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 participants, with at least one HIV medical provider visit in the measurement year.			
Prescription of HIV Antiretroviral Therapy	90% of Ryan White Part B program participants were prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year.	86%	87%	
	Numerator: Number of participants from the denominator prescribed HIV antiretroviral therapy during the measurement year.			
	Denominator: Number of participants with at least one HIV medical provider visit in the measurement year.			
HIV Medical Visit Frequency	68% of Ryan White Part B program participants 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.	63%	56%	
	Numerator: Number of participants in the denominator who had at least one HIV medical provider visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first HIV medical visit in the prior 6-month period and the last HIV medical visit in the subsequent 6-month period.			
	Denominator: Number of participants with at least one HIV medical visit in the first 6 months of the 24-month measurement period.			

Georgia Ryan White Part B Care Program				
Performance Measure	**Goal**	**Outcomes**		
		Dec 2016	**Dec 2017**	**2018**
Gap in HIV Medical Visits	Percent of Ryan White Part B program participants who did not have a HIV medical provider visit in the last 6 months of the measurement year will be less than 16%.	17%	24%	
	Numerator: Number of participants in the denominator who did not have a HIV medical provider visit in the last 6 months of the measurement year.			
	Denominator: Number of participants who had at least one medical provider visit in the first 6 months of the measurement year.			

VI. Data Collection

A. Data Collection Strategies

1. The HIV Data Team, HIV/AIDS Surveillance Unit, and others assist with data collection strategies.
2. Data Sources include the following:
    - CAREWare
    - RW Data Reports
    - Enhanced HIV/AIDS Reporting System (eHARS)
    - Vital Records
    - Clinical Chart Review Tool
    - Programmatic monitoring tools
    - Reports from funded agencies
    - Pharmacy Benefits Manager (PBM) database
    - Client satisfaction surveys
    - Case Management Chart Review Tool
    - Clinic/District specific surveys
3. Data collection is based on appropriate sampling methodologies.

B. Reporting Mechanisms

1. Ryan White Program Part B funded agencies are required to report data on key performance indicators.
2. The Core Team reviews and compiles findings.
3. District Liaisons and/or Ryan White Program Part B QM staff review sub-recipient QM plans and reports for effectiveness and accuracy.

4. Findings are shared with HIV providers, RW Program Part B funded agencies, Consortia, the Office of HIV/AIDS, the DPH leadership, and others.
5. Findings are used to guide CQI activities.

C. Performance Measurement

Key clinical and non-clinical performance indicators are measured statewide. (See Appendix D Monitoring Table). HRSA/HAB released new HIV Performance Measures (PM) in October 2013. New measures are integrated into review tools and CAREWare and prioritized.

1. HRSA/HAB introduced 5 new Core Measures and archived several measures. Four of five Core Measures are available in CAREWare. The Quarterly PM portfolio has been revised and updated. All 5 Core Measures have been integrated into the Clinical Chart Review and PMs for the Chart Review have also been revised.
2. The Part B District reports include performance measures from the Part B Implementation Plan.
3. The HIV Nurse Consultants and Medical Advisor review RW Program Part B HIV clinical charts for key clinical performance measures.
4. The QM Coordinator and HIV Nurse Consultants review case management charts for performance measures.
5. District Liaisons monitor selected general RW programmatic measures.
6. ADAP/HICP staff review ADAP and HICP performance measures through data reports.
7. Performance measures developed for the Ryan White Part B Program should also be used by Sub-recipients to assess the efficacy of the programs and to analyze and improve the gaps along the Continuum.

The following outlines the processes for ongoing evaluation and assessment:

1. Data is used to identify gaps in care and service delivery.
2. Evaluation of CQI projects is ongoing. The Work Plan is updated at least quarterly.
3. The Part B CAREWare database is utilized whenever possible to collect data for statewide performance measures.
4. RW Program Part B funded agencies monitor selected performance measures and report to the Program. The Core Team reviews these measures and compiles reports.
5. RW Program Part B funded agencies 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 D Monitoring Table)
6. HIV Nurse Consultants, QM Coordinator and the Medical Advisor review HIV clinical and case management charts in Part B-funded agencies 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.
7. The QM Coordinator monitors Ryan White Part B funded agencies for compliance with case management standards and performance measures.
8. The QM Core Team annually assesses the Clinical QM Program for effectiveness.

VII. Clinical Quality Management (CQM)

A. Quality Management Work Plan

- The QM plan includes a "living" Work Plan that is updated at least quarterly.
- The Work Plan specifies objectives and strategies for QM plan goals listed below in Continuous Quality Assurance and further detailed in the Clinical Work Plan included in Appendix A.

B. Continuous Quality Assurance (CQA) 2018-2019 Goals and Objectives

Goal 1: Continuously implement a statewide RW Part B Clinical Quality Management plan, which is updated at least annually.
Objectives include:

1.a. Provide quality improvement (QI)/quality management (QM) training workshops based on identified needs.
1.b. Assure that sub-recipients conduct at least one quality improvement project each the year.
1.c. Communicate findings to key stakeholders at least biannually.
1.d. Update the QM plan at least annually and the QM work plan at least quarterly.
1.e. Require that all RW Program Part B funded agencies revise written QM plans/workplans annually and submit quarterly QM 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 Ryan White Part B ADAP program participants and maintain viral load suppression at 80% or greater.
2.b. Monitor medical visit frequency among Ryan White Part B ADAP program participants and maintain at least 2 medical visits within 12 months.
2.c. Increase the percent of new ADAP applications approved or denied for ADAP enrollment within 2 weeks of ADAP receiving a completed application to 95% or greater.
2.d. Monitor the percent of Georgia ADAP clients who recertify semi-annually.
2.e. Monitor ADAP applications for completeness.
2.f. Conduct an internal audit of up to 5% of ADAP new client application forms annually.
2.g. Monitor programmatic compliance and adherence to antiretroviral regimens through the data collection system.
2.h. Systematically review data collected by the ADAP to identify inappropriate antiretroviral therapy (ART) regimens or components.

Goal 3: Improve efficiency of the Georgia Healthcare Insurance Continuation Program (HICP).
Objectives include:

3.a. Monitor viral load suppression among Ryan White Part B HICP program participants and maintain viral load suppression at 80% or greater.
3.b. Monitor client recertifications by due date to prevent delays in payments for health insurance premiums.
3.c. Monitor completeness of HICP applications submitted.
3.d. Conduct an annual audit of HICP client applications and/or recertification forms quarterly.

Goal 4: Improve the quality of health care and supportive services.
Objectives include:

4.a. Monitor performance measures, including stratified core measures in all 16 Part B funded agencies.
4.b. Design CQI project to analyze contributing factors related to the increased rate for Gap in Medical Visits.
4.c. Continually monitor the Acuity Scale and Self-Management Model.
4.d. Implement the *Georgia HIV/AIDS Case Management Standards*.
4.e. Coordinate quality-related activities across Ryan White Programs (Parts A, B, C, and D) in Georgia.
4.f. The percent of HIV-infected pregnant women prescribed antiretroviral therapy will be 95% or greater.
4.g. Monitor, assess and improve perinatal systems of care for HIV infected women and their infants.
4.h. Design and implement a statewide CQI Project with the aim to increase Consumer involvement in funded agencies and state level QM Committees.
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, Emerging Communit**ies** (EC) and Minority AIDS Initiative (MAI) program requirements.

C. Quality Management Plan Timeline

- The QM plan includes a timeline to ensure annual revision of the QM plan.
- The timeline incorporates development, implementation, and revision of the plan based on the Ryan White Program Part B grant year.
- The timeline includes quarterly QM Core Team meetings and progress reports. (See Appendix B)

D. Description of the CQM Program Performance Measures

- List the performance measure(s) for the upcoming project period for each funded service category(s) is included in Appendices D and E.

VIII. Clinical Quality Improvement

- The QM Core Team and/or the Office of HIV/AIDS Care Team select and prioritize statewide or system QI projects.
- Data is utilized to guide project selection.
- CQI Methodology is utilized and includes the following:
  - The Model for Improvement (PDSA [Plan/Do/Study/Act] Cycles). (See Appendix F).
  - Flow chart analysis
  - Cause and effect diagrams
  - Brainstorming
  - Observational studies/ client flow
  - Activity logs
- Improvement projects are documented in the Clinical QM Work Plan.
- Sub-recipient QM plans include CQI projects.
- Sub-recipients will report progress on CQI projects quarterly.

A. CQI Projects and Goals:

CQI projects are detailed in the Clinical QM Work Plan included as Appendix A in an attached file. 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.

1. The QM plan includes a "living" Work Plan that is updated at least quarterly.
2. The Work Plan specifies objectives and strategies for QM Plan goals. (The Clinical Work Plan is attached in a separate file as Appendix A)
   - The two previous CQI projects have ended and findings are included in QM Core Team meeting minutes.
   - The following statewide clinical CQI projects are included in this plan and project details will be developed and detailed in the Work Plan (Appendix A.) Projects were selected to align with overarching National HIV/AIDS Strategy, Georgia RW Part B Program outcomes on HAB Performance Measures and HRSA recommendations.
   - Improve rates for Medical Visit Frequency and/or decrease Gap in HIV Medical Visits:
     - Use CAREWare data to assess and measure rates
     - Review processes for CAREWare data entry and provide technical assistance, as needed
     - Identify and share best practices for appointment processes, client 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
     - Encourage sub-recipients to implement clinic specific CQI projects with the aim to improve these measures

- Increase sub-recipient and State-level Consumer membership and involvement in QM Committees.
    - Complete PDSA cycle with sub-recipients
    - Research models to increase consumer involvement
    - Research best practices to increase consumer involvement in RW Programs
    - Enlist support and technical assistance from CQII

APPENDICES

Appendix A
Clinical Quality Management Work Plan

(See attached file. The Work Plan is updated quarterly)

Georgia Ryan White Part B Program Clinical Quality Management 2018-2019 Work Plan

Goal 1: Continuously implement a statewide RW Program Part B Clinical Quality Management (QM) Plan, which is updated at least annually.

Objectives	Strategies	Lead	Staff Resources	Timeline	Progress Notes
1-1 Provide quality improvement (QI) / quality management (QM) training workshops based on identified needs.	1-1.a. Plan and conduct two quality management trainings based on identified needs. 1-1.b. Consider using webinars to share best practices and provide QM training. 1-1.c. Collaborate with partners to implement clinical and/or case management training based on identified needs.	Sandra Metcalf, Pamela Phillips	Part A HIV Qual Consultant Care Team	1-1.a. TBD 1-1.b. As needed 1-1.c. As needed	
1-2 Assure that sub-recipients conduct at least one quality improvement project each year.	1-2.a. Facilitate system improvements by utilizing CQI methodologies. 1-2.b. Review local CQI projects and provide technical assistance (TA). 1-2.c. Meet with and provide onsite TA to local QM committees. 1-2.d. Monitor funded agencies quarterly QM reports for CQI and best practices. 1-2.e. Showcase CQI best practices. 1-2.f. Share updates and solicit input from QM Core Team regarding statewide improvement efforts.	Sandra Metcalf, Pamela Phillips	Care Team Training materials and assessment tools District Liaisons Local Committees	1-2.a. Quarterly 1-2.b. Quarterly 1-2.c. As needed 1-2.d. Quarterly 1-2.e. TBD 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 QM information on the Office of HIV/AIDS web page. 1-3.d. Explore strategies to involve funded agencies in the statewide quality process.	Sandra Metcalf, Pamela Phillips	QM Core Team Care Team	1-3.a. TBD 1-3.b. As needed 1-3.c. As needed 1-3.d. As needed	
1-4 Update the QM plan at least annually and the QM work plan at least quarterly.	1-4.a. Revise work plan quarterly. 1-4.b. Share QM Plan with DPH and Office of HIV/AIDS stakeholders. 1-4.c. Place revised QM plan on Office of HIV/AIDS web pages.	Sandra Metcalf, Pamela Phillips	QM Core Team Care Team	1-4.a. Quarterly 1-4.b. Annually 1-4.c. Annually	
1-5 Require that all RW Program Part B funded agencies revise written QM plans/work plans annually and submit quarterly QM progress reports to include CQI project updates.	1-5.a. Obtain quarterly QM reports from the Part B funded agencies and monitor QM activities (CQI project updates), work plan and PMs. 1-5.b. Review revised QM plans from each Part B funded agency. 1-5.c. Provide feedback on local QM plans to the funded health agency.	Sandra Metcalf, Pamela Phillips District Liaisons	District HIV Coordinators and Local QM Committees QM Core Team	1-5.a. Quarterly 1-5.b. Per annual renewal date 1-5.c. Per annual renewal date	

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 Ryan White Part B ADAP program participants and maintain viral load suppression at 80% or greater.	2-1.a. Create quarterly report from the CAREWare database 2-1.b. Review ADAP clients who adhere to at least 2 visits for routine HIV medical care in 12 months 2-1.c. Utilize the reports to communicate with the district and enrollment staff 2-1.d. Share finding with GA ADAP/HICP QM Workgroup	Satin Francis	Satin Francis Alysia Johnson Data CAREWare Team	2-1.a. Quarterly 2-1.b. Quarterly 2-1.c. Quarterly 2-1.d. Quarterly	
2-2 Monitor medical visit frequency among Ryan White Part B ADAP program participants and maintain at least 2 medical visits within 12 months.	2-2.a. Monitor medical visits within 12 month period. 2-2.b. Create quarterly report from CAREWare monitoring medical visit frequency among Ryan White Part B ADAP program participants. 2-2.c. Share findings and solicit input from QM Core Team regarding statewide improvement efforts if needed. 2-2.d. Utilize report to communicate with district and agency staff regarding client's medical visit frequency.	Satin Francis	Satin Francis Alysia Johnson Data CAREWare Team	2-2.a. Quarterly 2-2.b. Quarterly 2-2.c. Quarterly 2-2.d. Quarterly	
2-3 Increase the percent of new ADAP applications approved or denied for ADAP	2-3.a. Generate monthly reports to monitor this objective and share quarterly with the ADAP/HICP Subcommittee.	Satin Francis, Alysia Johnson, and	Pamela Phillips ADAP Team	2-3.a. Monthly, quarterly 2-3.b. Quarterly	

enrollment within 2 weeks of ADAP receiving a complete application to 95% or greater.	2-3.b. Evaluate reports for trends in ADAP Office of HIV/AIDS performance in processing new applications. 2-3.c. Conduct CQI projects to decrease length of time to determine ADAP eligibility or ineligibility by ADAP Office of HIV/AIDS. 2-3.d. Utilize reports to communicate with district and agency staff regarding their rates of correctly completed ADAP application submissions. 2-3.e. Provide technical assistance on ADAP applications and required supporting documentation to staff and agencies. 2-3.f. Ensure that ADAP coordinators and case managers comply with the approved Georgia Ryan White Part B/ADAP/HICP Policies and Procedures. 2-3.g. Provide or coordinate ADAP-related training for ADAP/ HICP Enrollment Site Coordinators and case manager. 2-3.h. Communicate GA ADAP updates via conference calls, email listserv, and Office of HIV/AIDS web pages. 2-3.i. Convene the Georgia ADAP/HICP Quality Management Subcommittee as needed.	CAREWare Data Team		2-3.c. As needed 2-3.d. Quarterly 2-3.e. As needed 2-3.f. During internal review as needed 2-3.g. As needed 2-3.h. As needed 2-3.i. As needed	

2-4 Monitor the percent of Georgia ADAP clients who recertify semi-annually.	2-4.a. Generate monthly reports to monitor this objective and share quarterly with the ADAP/HICP Subcommittee. 2-4.b. Utilize reports to communicate with district and agency staff regarding clients' recertification status. 2-4.c. Monitor the ADAP enrollment sites systems to track ADAP client recertification due dates. 2-4.d. Provide technical assistance to those who need assistance developing or improving their system to track ADAP client recertification due dates. 2-4.e. Ensure that ADAP coordinators and case managers comply with the approved Georgia ADAP Policies and Procedures manual. 2-4.f. Provide or coordinate ADAP related training for ADAP/ HICP Enrollment Site Coordinators and case managers. 2-4.g. Conduct administrative site visits. 2-4.h. Communicate GA ADAP updates via conference calls, email listserv and Office of HIV/AIDS web pages. 2-4.i. Convene the Georgia ADAP/ HICP Quality Management Workgroup at least quarterly. 2-4.j. Generate reports of the percent of discontinued clients enrolling in	Satin Francis, Alysia Johnson, and CAREWare Data Team	Pamela Phillips ADAP Team	2-4.a. Monthly, quarterly 2-4.b. Monthly. 2-4.c. During admin. site visits as needed 2-4.d. As needed 2-4.e. During internal review as needed 2-4.f. As needed on location or at the Office of HIV/AIDS 2-4.g. Annually 2-4.h. As needed 2-4.i. As needed 2-4.j. Monthly, quarterly	

	ADAP, and share quarterly with the ADAP/HICP Subcommittee.				
2-5 Monitor ADAP applications for completeness**.**	2-5.a. Generate monthly reports to monitor this objective, and share quarterly with ADAP/ HICP Workgroup. 2-5.b. Utilize reports to communicate with district and agency staff regarding their rates of correctly completed new ADAP application submissions. 2-5.c. Provide technical assistance on ADAP applications and backup documentation to staff and agencies as needed. 2-5.d. Ensure that ADAP coordinators and case managers comply with the approved Georgia Ryan White Part B/ADAP/ HICP Policies and Procedures. 2-5.e. Provide or coordinate ADAP related training for ADAP/ HICP Enrollment Site Coordinators and case managers as needed. 2-5.f. Communicate GA ADAP updates via conference calls, email listserv, and Office of HIV/AIDS web pages. 2-5.g. Convene the Georgia ADAP/ HICP Quality Management Workgroup as needed.	Satin Francis, Alysia Johnson, and CAREWare Data Team	Pamela Phillips ADAP Team	2-5.a. Monthly 2-5.b. Quarterly 2-5.c. As needed 2-5.d. During internal reviews as needed 2-5.e. As needed 2-5.f. As needed 2-5.g. As needed	

2-6 Conduct an internal audit of up to 5% of ADAP new client application forms annually.	2-6.a. Review complete audit of all active client files. 2-6.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. 2-6.c. For applications and forms that were incomplete, request and obtain required documentation. 2-6.d. Create quarterly Report Card from CAREWare summarizing key findings. 2-6.e. Share findings with ADAP district or agency enrollment sites. 2-6.f. Share findings with the GA ADAP/HICP QM Workgroup to initiate CQI projects as indicated.	Satin Francis and Alysia Johnson	ADAP Team QM Team	2-6.a. Annually 2-6.b. Daily 2-6.c. As needed 2-6.d. Quarterly 2-6.e. Quarterly 2-6.f. Quarterly	
2-**7** Monitor programmatic compliance and adherence to antiretroviral regimens through the data collection system.	2-7.a. Instruct funded agencies to utilize PBM reports to routinely monitor clients who pick up medications from the ACP Networks. 2-7.b. Review PBM compliance/ adherence reports. 2-7.c. Provide medication adherence training to ADAP contract pharmacies. 2.7.d. Conduct ACP Network audits.	Gay Campbell	Gay Campbell Satin Francis Alysia Johnson	2-7.a. Quarterly 2-7.b. Quarterly 2-7.c. As needed 2-7.d As needed	
2-8 Systematically review data collected by the ADAP to identify inappropriate	2-8.a. Discuss with PBM how to best monitor for inappropriate ART regimens or components including the development of electronic reports and	Gay Campbell	Gay Campbell Dr. Felzien	2-8.a. As needed 2-8.b. As needed	

antiretroviral therapy (ART) regimens or components.	real time hard-halt adjudication rejections at pharmacy point of service if inappropriate regimens are prescribed. 2-8.b. Review PBM reports and pharmacy audit tools to monitor inappropriate ART regimens or components. 2-8.c. Utilize PBM reports and pharmacy audit tools to provide training and assistance to ACP Network regarding inappropriate ART regimens or components. 2-8.d. Require ADAP contract pharmacies to maintain a separate ADAP medication error log. 2-8.e. Provide access to current updates of HIV and related medication guidelines and resources for ACP Network, 2-8.f. Provide updates to the DPH HIV/Antiretroviral Quick Sheet in accordance with current HHS Guidelines.			2-8.c. As indicated during audits 2-8.d. As indicated during audits 2-8.e. As needed 2-8.f. As needed	

Goal 3: Improve efficiency of the Georgia Healthcare Insurance Continuation Program (HICP).

Objectives	Strategies	Lead	Staff Resources	Timeline	Progress Notes
3-1 Monitor viral load suppression among Ryan White Part B HICP program participants and maintain viral load suppression at 80% 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. Review HICP clients who adhere to at least 2 visits for routine HIV medical care in 12 months 3-1.d. Share finding with GA ADAP/HICP QM Workgroup	Satin Francis	Satin Francis Alysia Johnson Data CAREWare Team	3-1.a. Quarterly 3-1.b. Quarterly 3-1.c. Quarterly 3-1.d. Quarterly	
3-2 Monitor client recertifications by due date to prevent delays in payments for health insurance premiums.	3-2.a. Generate monthly reports to monitor this objective. 3-2.b. Utilize reports to communicate with district and agency staff regarding clients' recertification status. 3-2.c. Provide technical assistance on HICP applications and backup documentation to staff and agencies 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	Satin Francis, Alysia Johnson, and CAREWare Data Team	HICP Team District Liaisons QM 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. As needed 3-2.g. Monthly 3-2.h. As needed	

	Enrollment Site Coordinators and case managers. 3-2.g. Communicate GA HICP updates via conference calls, email listserv, and HIV Office web pages. 3-2.h. Convene the Georgia ADAP/ HICP Quality Management Workgroup as needed.				
3-3 Monitor completeness of HICP applications submitted.	3-3.a. Generate monthly reports to monitor this objective and share quarterly with the ADAP/HICP Workgroup 3-3.b. Utilize the reports to communicate with the 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.	Satin Francis, Alysia Johnson and CAREWare Data Team	HICP Team District Liaisons QM Team	3-3.a. Monthly 3-3.b. Quarterly 3-3.c. As needed 3-3.d. Daily 3-3.e. As needed	
3-4 Conduct an annual audit of HICP client applications and/or recertification forms quarterly.	3-4.a. Review complete audit of all active client files. 3-4.b. Utilize the "HICP Documentation Checklist" to evaluate if HICP applications or recertification forms were correctly completed and if approved or	Satin Francis and Alysia Johnson	HICP Team QM Team	3-4.a. Annually 3-4.b. Daily 3-4.c. As indicated	

	denied according to HICP policies and procedures. 3-4.c. For application forms that were incomplete, request and obtain required documentation. 3-4.d. Create quarterly report card from CAREWare summarizing key findings. 3-4.e. Share findings with the ADAP/HICP QM subcommittee Workgroup to initiate CQI projects as indicated.			3-4.d. Quarterly 3-4.e. Quarterly	

Goal 4: Improve the quality of health care and supportive services.

Objectives	Strategies	Lead	Staff Resources	Timeline	Progress Notes
4-1 Monitor performance measures, including stratified core measures, in all 16 Part B funded agencies.	4-1.a. Include HAB measures in monitoring tools, chart reviews, and QM 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 Measure data and reports. 4-1.d. Conduct clinical and CM chart reviews.	Sandra Metcalf, Pamela Phillips Roderick Newkirk	QM Core Team District Liaisons	4-1.a. As needed 4-1.b. Quarterly 4-1.c. As needed 4-1.d. Annually	

4-2 Design CQI project to analyze contributing factors related to the increased rate for Gap in Medical Visits.	4-2.a. Develop a PDSA to analyze contributing factors related to the increased rate for Gap in Medical Visits. 4-2.b. Track statewide data for Gap in Medical Visits via the quarterly HAB Report 4-2.c. Consult with funded agencies and CAREWare Operations Analyst to increase knowledge of data entry processes. 4-2.d. Collect data via quarterly reports on missed appointment follow-up. 4-2.e. Share best practices with funded agencies. 4-2.f. Assist funded agencies as needed to develop CQI projects to reduce Gap in Medical Visits rates.	Sandra Metcalf, Pamela Phillips	QM Core Team Care Team HRSA/HAB Center for Quality Improvement and Innovation	4-2.a. 8/31/2018 4-2.b. Ongoing 4-2.c. Ongoing 4-2.d. Quarterly 4-2.e. Annually 4-2.f. Quarterly	
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 funded agencies utilizing an acuity scale and self-management model.	Pamela Phillips and CM Subcommittee	QM Core Team	4-3.a. 3/31/2019 4-3.b. As needed	
4-4 Implement the *Georgia HIV/AIDS Case Management Standards.*	4-4.a. Distribute revised CM Standards document to the HIV Coordinator in each funded agency via email. 4-4.b. Provide technical assistance to funded agencies to assist with implementation of the CM Standards.	Pamela Phillips and CM Subcommittee	QM Core Team	4-4.a. 4/15/18 4-4.b. As needed	

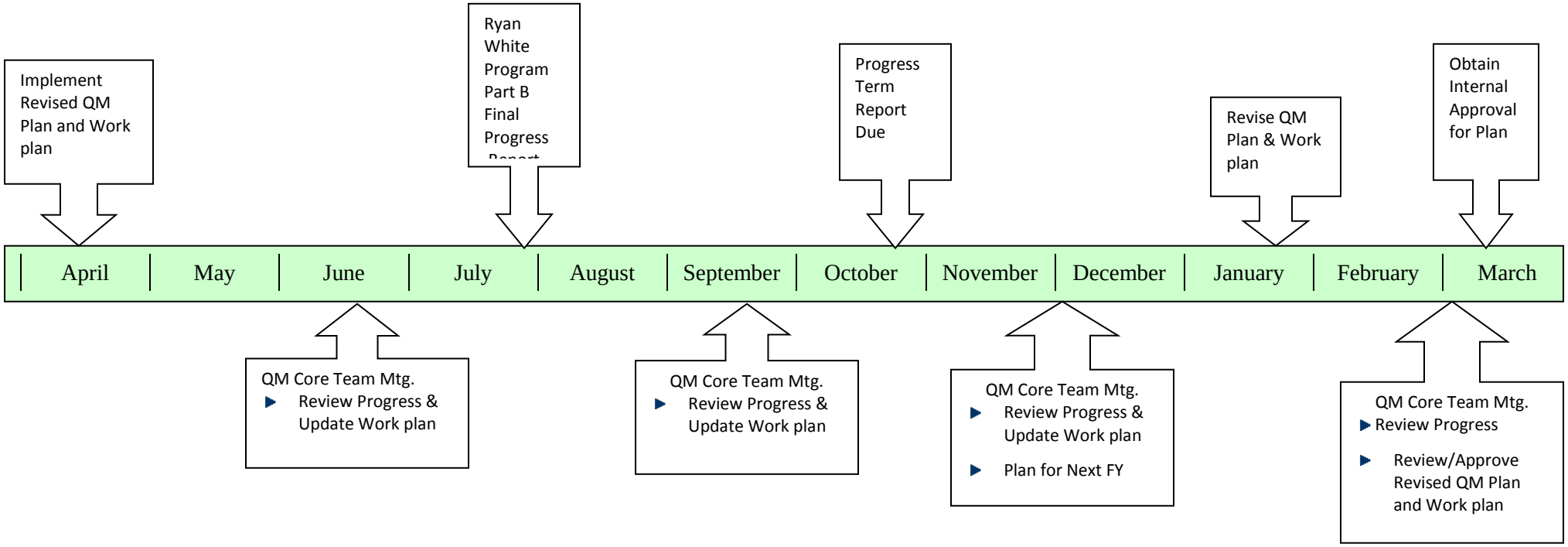
4-5 Coordinate quality-related activities across Ryan White Programs (Parts A, B, C, and D) in Georgia.	4-5.a. Attend the Part A Planning Council and QM Committee. 4-5.b. Include across Ryan White Programs representation on the Part B QM Core Team. 4-5.c. Provide quality-related training to RW staff statewide based on identified needs. 4-5.d. Coordinate quality training efforts with GA AETC. 4-5.e. Participate in Integrated Planning efforts.	Sandra Metcalf, Pamela Phillips	Part A QM Committee Part B QM Core Team GA AETC	4-5.a. Monthly 4-5.b. Quarterly 4-5.c. As needed 4-5.d As needed 4-5.e As needed	
4-6 The percent of HIV-infected pregnant women prescribed antiretroviral therapy will be 95% or greater.	4-6.a. As part of the RW Program Part B clinical chart review, assess management of pregnant HIV-infected women.	Rhonda Harris, Dr. Felzien and Sandra Metcalf	QM Core Team	4-6.a. Ongoing	
4-7 Monitor, assess and improve perinatal systems of care for HIV infected women and their infants.	4-7.a. Develop a Perinatal Working Group to meet and identify socioeconomic issues that affect HIV positive pregnant women and develop recommendations for systemic improvement. 4-7.b. Collaborate with each Care Management Organization (CMO) to strengthen the enrollment of case management for members that are HIV positive, pregnant, and demonstrate need for service. 4-7.c. Reinforce the usage of the Clinician Consultation Center "warm	Rhonda Harris	Rhonda Harris Perinatal Working Group QM Core Team	4-7.a. Ongoing 4-7.b. Ongoing 4-7.c. Ongoing 4-7.d. Ongoing	

	line" to assist providers with questions and concerns regarding Perinatal HIV care. 4-7.d. Train providers in rural areas on Perinatal HIV care, so patients will not have to travel to Metro Atlanta for care.				
4-8 Design and implement a statewide CQI Project with the aim to increase Consumer involvement in funded agencies and state level QM Committees.	4-8.a. Complete PDSA cycle with funded agencies. 4-8.b. Research models to increase consumer involvement. 4-8.c. Showcase best practices to increase consumer involvement in RW Part B Programs. 4-8.d. Enlist support and technical assistance from CQII. 4-8.e. Collect data from funded agencies on consumer involvement and recruiting initiatives. 4-8.f. Report on project at quarterly QM Core Team meetings.	Sandra Metcalf, Pamela Phillips	QM Core Team Care Team HRSA/HAB Center for Quality Improvement and Innovation	4-8.a. Ongoing 4-8.b. 7/1/2018 4-8.c. Annually 4-8.d. As needed 4-8.e. Semiannually 4-8.f. Quarterly	
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 funded agencies with compliance.	Mirelys Ramos, Rolanda Hall, DeWan Green, Eric Wade, and Shandrecka Murphy	HIV Care Team	4-9.a. As needed 4-9.b. As needed	
4-10 Monitor compliance with RW Program Part B,	4-10.a. Conduct site visits and provide summary reports, including feedback as appropriate.	Mirelys Ramos, Rolanda Hall,	Sandra Metcalf and	4-10.a. Ongoing	

Emerging Communities (EC) and MAI program requirements.	4-10.b. Update site visit tools for funded agencies and contractors in accordance with federal program requirements. 4-10.c. Assess services provided at the district level and share common findings with the QM Core Team. 4-10.d. Provide technical assistance to funded agencies in need of compliance support. 4-10.e. Develop processes to improve compliance with RW Program Part B, EC, and MAI program requirements for applicable funded agencies.	DeWan Green, Eric Wade, and Shandrecka Murphy	Pamela Phillips	4-10.b. Annually 4-10.c. Quarterly and as needed 4-10.d. As needed 4-10.e. As needed	

Appendix B
Annual Clinical QM Plan Timeline

Annual Clinical QM Plan Timeline



Appendix C
2018-2019 Ryan White Part B Program
Clinical Quality Management Committees

Ryan White Part B Clinical QM Program
2018-2019 Quality Management Core Team Members

- Ada Figueroa-Monell, RN-BSN, Specialty Care Clinic Manager
- Adolphus "Tony" Major, Lead Client Advocate/ Program Assistant
- Alysia Johnson, BHS, ADAP/HICP Assistant Manager
- Chris Morfaw, RN, Public Health Nurse Director
- Deborah "Deb" Bauer, MPH, Ryan White (Part D)
- DeWan Green, MPA, District Liaison
- Ebony Wardlaw, HIV Data Manager
- Eric Wade, BS, District Liaison
- Erin Wust, Community Health Nurse/Case Manager
- Flossie Loud, BSW, SST III
- Gay Campbell, RPh, ADAP Pharmacy Director
- Gregory Felzien, MD, AAHIVS, Medical Advisor, Division of Health Protection/IDI-HIV
- Jamila Booker, Quality Coordinator
- Janet Eberhart, RN-BSN, District Immunization Coordinator
- Jeffery Vollman, MPA, District HIV Director
- Jocelyn McKenzie, MPH, Quality Management Program (Part A)
- John Rogers, HIV Coordinator
- Karla Henriquez, Administrative Assistant Supervisor
- LaKecia Joy Vanerson, MPA, Business Support Analyst 3
- Malela Rozier, MSW, MA, BS, HIV Program Coordinator
- Marisol Cruz, DBA, MS, HIV Care Manager
- Mirelys M. Ramos, MPH, CHES, Assistant HIV Care Manager
- Pamela Phillips, MSA, BSW, Part B QM Coordinator
- Rhonda Harris, MPH, MS, Perinatal Coordinator
- Rodrick Newkirk, Database Analyst II
- Rolanda Hall, MPH, District Liaison
- Rosemary Donnelly, MSN, ANP-BC, ACRN, Director of Clinical Care
- Sandee Jump, MPH, LMSW, Wellness Program Coordinator
- Sandra Metcalf, RN, MPH, ACRN, HIV Nurse Consultant
- Satin Francis, ADAP/HICP Program Manager
- Shandrecka Murphy, MPH, District Liaison
- Somo Hubbard, Register Nurse/Quality Assurance RN
- Sonya Wilson, Administrative Assistant 1
- Susan Alt, BSN, ACRN, District HIV Director

Ryan White Part B Clinical QM Program
2018-2019 Case Management Sub-Committee

- Adolphus “Tony” Major, Lead Consumer Advocate/ Program Assistant
- Casey Messer MDPAS, PA-C, AAHIVS, Client Services Coordinator
- Dale Wrigley, Director Hope Center
- Elizabeth "Michelle" Mercer, BS, Case Manager
- Flossie Loud, BSW, SST III
- Ginny Price, BSN, RN Case Manager
- Hawa Kone, MS, Program Coordinator
- Janet Eberhart, RN-BSN, District Immunization Coordinator RW Part B Coordinator
- Jeffery D. Vollman, MPA, District HIV Director
- Jenetter Richburg, Director of Client Services
- Karen W. Cross, LCSW, Director of Client Services
- Kathryn Arnold, MSA, Social Worker
- Kim Wasley, LMSW, Case Manage
- LaShawne Graham, MEd, BSW, Social Worker
- LaToya Robinson, BSW, ADAP Coordinator, SSP III
- Melita Lowe, MS, Case Management Supervisor
- Nicole Roebuck, MSW, AID Atlanta Executive Director
- Pamela Phillips, MSA, BSW, Quality Management Coordinator
- Sandra Metcalf, RN, MPH, ACRN, HIV Nurse Consultant
- Sheryl Lewis, MBA, Program Consultant/Case Manager
- Tenell Davis, BS, Case Manager Supervisor
- Tonya Gibson, Medical Case Manager

Ryan White Part B Clinical QM Program
2018-2019 Georgia ADAP/HICP Sub-Committee

- Alysia Johnson, BHS, ADAP/HICP Assistant Manager
- Gay Campbell, RPh, ADAP Pharmacy Director
- Gregory S. Felzien, MD, AAHIVS, Medical Advisor, Division of Health Protection/IDI-HIV
- Marisol Cruz, DBA, MS, HIV Care Manager
- Mirelys M. Ramos, MPH, CHES, Assistant HIV Care Manager
- Sandra Metcalf, RN, MPH, ACRN, HIV Nurse Consultant
- Satin Francis, ADAP/HICP Program Manager

Appendix D
Service Category
Performance Measure Table

The following is an abbreviated list of Performance Measures. Additional Performance Measures can be found in Appendix E.

Service Category	Performance Measure(s)
Outpatient/Ambulatory Medical Care (OAMC)	• Among those clients who received OAMC, percentage of patients, regardless of age, 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. • Percentage of clients, regardless of age, with a diagnosis of 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.
Oral Health	Percent of patients with a diagnosis of HIV who received an oral exam by a dentist at least once during the measurement year.
Health Insurance & Cost Sharing Assistance	Among those clients who receive health insurance and cost sharing assistance, the percentage of patients, regardless of age, 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.
Mental Health Services	• Among those clients that received mental health services, the percentage of patients, regardless of age, 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. • Among those clients that are HIV positive, the percentage of new clients who have had a mental health screening.
Medical Nutrition Therapy	Among those clients who receive medical nutrition therapy, the percentage of patients, regardless of age, 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.
Medical Case Management(MCM) Services	• Percent of MCM patients, regardless of age, with a dx of HIV who had a MCM Care Plan developed and/or updated two or more times in the measurement year. • Percent of MCM patients, regardless of age, with a dx of HIV who did not have a medical visit in the last 6 months of the measurement year (that is documented in the MCM record). • Percent of MCM patients, regardless of age, with a dx of 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.
Substance Abuse Services	Among clients with HIV infection, the percentage of new clients who have been screened for substance use.

Case Management (non-Medical)	• Percentage of Case Management (non-Medical) clients, regardless of age, with a diagnosis of 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. • Percentage of correctly completed new ADAP applications submitted.
Emergency Financial Assistance	Among those clients who receive emergency financial assistance, the percentage of patients, regardless of age, with a diagnosis of 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
Food Bank/Home-Delivered Meals	Among those clients who receive food bank/home-delivered meals, the percentage of patients, regardless of age, with a diagnosis of 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.
Health Education/Risk Reduction	Among those clients who are HIV infected, the percentage of patients with a diagnosis of HIV who received HIV risk counseling in the measurement year
Linguistic Services	Among those clients who receive linguistic services, the percentage of patients, regardless of age, with a diagnosis of 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.
Medical Transportation Services	Among those clients who receive medical transportation dollars, the percentage of patients, regardless of age, with a diagnosis of 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
Psychosocial Support Services	Among those clients who receive psychosocial support services, the percentage of patients, regardless of age, with a diagnosis of 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
Treatment Adherence Counseling	Among those clients who receive treatment adherence counseling, the percentage of patients, regardless of age, 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

AIDS Drug Assistance Program (ADAP)	• Among those clients who receive ADAP, the percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 12-month measurement period with a minimum of 60 days between medical visits. • Among those clients who receive ADAP, the percentage of patients, regardless of age, 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.

Appendix E
Monitoring Table

Georgia HIV Client Services Clinical Quality Management Program Monitoring Table

Note: For data collected through client record or chart review, the denominator of the Measure is calculated according to sample size of charts provided for review.

Measures with a numerator or denominator stating, "medical visit with a provider with prescribing privileges" or similar are captured according to the current CAREWare service categories.

Additional Performance Measures can be found in Appendix D.

Criteria	Indicators	Data Elements	Data Sources & Methods
General Ryan White Program Performance Measures			
Ryan White funds are used as payer-of-last-resort.	Clients screened for other healthcare providers and insurance. Eligible clients referred for enrollment into Private Insurance, Medicare, or Medicaid	Documentation indicating that clients are screened at intake and recertified every 6 months. Documentation that clients are referred for enrollment into Private Insurance, Medicare or Medicaid.	Client record review
Eligibility documented for all clients receiving Ryan White Program Part B services: - HIV status - Income - Proof of residency - Other healthcare coverage	Documented HIV+ status. Clients with documentation of financial screening initially then every 6 months; and income at or below 400% of FPL. Documentation of GA residency. Documentation of "vigorous pursuit" and other coverage including Private Insurance, Medicare, or Medicaid.	Documentation of HIV test result or physician signed statement of HIV infection. Documentation of financial screening, proof of residency, and healthcare coverage status at intake and every 6 months.	Client 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. Funded agencies 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 client satisfaction surveys.
Client 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 client charts and other information. Computers password protected and secure while in use. Layout of clinic prevents unauthorized access to records and computers.	Review of employee files. Observation of security/ confidentiality measures. Review of written policy and procedures regarding security and confidentiality.
Ryan White funded providers ensure that every client is informed about: - Client confidentiality - Client grievance - Client rights & responsibilities	Percent of clients informed of confidentiality policy, grievance policies and procedures, and rights and responsibilities.	Documentation in chart that client is informed of confidentiality policy, grievance policies and procedures, and rights and responsibilities initially then annually.	Client record review
HIV-infected clients are satisfied with the Ryan White Program Part B services they receive.	Percent of clients who indicate they are satisfied with the services they have received.	Client responses to questions about their satisfaction with specific services.	Review of District level annual client satisfaction survey results.

Criteria	Indicators	Data Elements	Data Sources & Methods
Ryan White-funded providers implement QM Plans with continuous quality improvement (CQI) projects.	Percent of Ryan White Part B-funded programs with written quality management plans and a current report of CQI activities and results.	Written Quality Management Plan. Copies of the most current report of CQI activities and results.	Review of quality management plans and reports.
Case Management Performance Measures			
All newly enrolled or reactivated case management clients will have an Intake, Acuity Scale, and Individualized Service Plan (ISP), and progress/case note completed within 15-30 days of initial intake assessment.	Percent of newly enrolled or reactivated case managed client 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: # of newly enrolled or reactivated case managed client 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: # of newly enrolled or reactivated case managed client during the measurement year.	Client Chart Review
All newly enrolled or reactivated case management clients will have an Intake, Acuity Scale, and Individualized Service Plan (ISP), and progress/case note completed within 15-30 days of initial intake assessment.	Percent of newly enrolled or reactivated case managed client 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: # of newly enrolled or reactivated case managed client 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: # of newly enrolled or reactivated case managed client during the measurement year.	Client Chart Review

Criteria	Indicators	Data Elements	Data Sources & Methods
Ensure that the Acuity Scale is updated every 3-6 months in accordance with the Activities by Acuity Level Document.	Percent of chart that have an Acuity Scale updated every 3-6 months in accordance with the Activities by Acuity Level Document during the measurement period.	N: # 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: # of case management charts that had an updated Acuity Scale during the measurement year.	Client Chart Review
All case management clients should have periodic 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 client charts with documented evidence of periodic re-evaluation and adaptation of the ISP at least every 3-6 months.	N: # of case management client 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: # of case managed clients in a measurement year.	Client chart review
Ensure that clients receiving case management services have continuous monitoring to assess the efficacy of the ISP.	Percent of client charts with documented evidence of ongoing monitoring to assess the efficacy of the ISP.	N: # of client charts with documented evidence of ongoing monitoring to assess the efficacy of the ISP during the measurement year. D: # of medically case managed clients in a measurement year.	Client chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
Ensure that clients receiving medical case management (MCM) services have (acuity level 3-4) documentation which includes coordination and follow up of medical treatment.	Percent of client chart (acuity level 3-4) documentation which includes coordination and follow-up of medical treatment.	N: # of MCM client charts (acuity level 3-4) with documentation including coordination and follow-up of medical treatment. D: # of MCM clients in a measurement year.	Client chart review
Clients receiving MCM services (acuity level 3-4) will have treatment adherence assessed at least every 4 months.	Percent of MCM clients (acuity level 3-4) who's charts had a documented treatment adherence visit 2 or more times at least 4 months apart.	N: # of MCM clients (acuity level 3-4) who had a documented treatment adherence visit 2 or more times at least 4 months apart in a measurement year. D: # of MCM clients in the measurement year.	Client chart review
All MCM clients (acuity level 3-4) who did not have a medical visit in the last 6 months as documented by case manager. (Gap in HIV medical visit)	Percent of MCM client (acuity level 3-4) charts who did not have a medical visit in the last 6 months.	N: # of MCM client (acuity level 3-4) charts who did not have a medical visit in the last 6 months during the measurement year. D: # of case managed clients in a measurement year.	Client chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
All MCM client charts (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. (MCM Medical: Visit Frequency)	Percent of MCM client charts (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: # of MCM client charts (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: # of MCM clients in a measurement year.	Client chart review
All case managed client 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 clients are eligible.	Percent of client chart documentation must reflect assistance with linkage to other programs for which clients are eligible.	N: # of client charts with documentation reflecting assistance with linkage to other programs for which clients are eligible during the measurement year. D: # of case managed clients in a measurement year.	Client chart review
All case managed clients (all levels of acuity) must have documented evidence of ongoing assessment of client and other key family members' needs and personal support system as needed.	Percent of client charts (all levels of acuity) who had documented evidence of ongoing assessment of client and other key family members' needs and personal support system, as needed.	N: # of client charts (all levels of acuity) with documented evidence of ongoing assessment of client and other key family members' needs and personal support system, as needed. D: # of case managed clients in the measurement year.	Client chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
Documentation should reflect that client specific advocacy has occurred during service provision (all levels of acuity).	Percent of client charts who had documented evidence of client advocacy (e.g., promotion of client needs for: transportation, housing or/and scheduling of appointments) has occurred during service provision.	N: # of client charts who had documented evidence of client advocacy (e.g., promotion of client needs for: transportation, housing or/and scheduling of appointments) has occurred during service provision in a measurement year. D: # of case managed clients in the measurement year.	Client chart review
Ensure that benefits/entitlement counseling and referral services were provided to access other public and private programs, as needed to eligible clients for all levels of acuity.	Percent of client's charts who had documented that benefits/entitlement counseling and referral services were provided.	N: # of client charts who had documented evidence that benefits/entitlement counseling and referral services were provided in the measurement year. D: # of case managed clients in the measurement year.	Client chart review
Case management client documentation (all levels of acuity) must ensure that housing referrals include: housing assessment, search, placement, advocacy, and financial assistance received for which clients are eligible.	Percent of case managed client charts who had documented housing referrals include: housing assessment, search, placement, advocacy, and financial assistance received.	N: # of case managed client charts who had documented housing referrals include: housing assessment, search, placement, advocacy, and financial assistance received in the measurement year. D: # of case managed clients in the measurement year.	Client chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
Case managed client documentation (all levels of acuity) must reflect that clients received assistance in obtaining stable long-term housing as needed.	Percent of case managed client charts who had documentation reflecting that clients received assistance in obtaining stable long-term housing.	N: # of case management clients chart who had documentation reflecting that clients received assistance in obtaining stable long-term housing in the measurement year. D: # of case managed clients in the measurement year.	Client chart review
All Case management chart documentation of services and encounters must include: - Client Identifier on all pages - Date of each encounter - Types of services provided - Types of encounters/ (face-to-face, telephone contact, etc.) - communication - Duration and frequency of encounters	Percent of client charts who had documented services and encounters.	N: # client charts who had documented services and encounters. D: # of case management clients in the measurement year.	Client chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
All case management case note documentation must be written in either Assessment, Plan, Intervention, and Assessment (APIE) or Subjective, Objective, Assessment, and Plan (SOAP) format case note in accordance with the GA Case Management Standards.	Percent of case notes documentation that reflect APIE or SOAP format was utilized in accordance with the GA Case Management Standards.	N: # of charts that had utilized APIE or SOAP format case note documentation. D: # of client charts in the measurement year.	
All entries in the client record by the case manager should contain the case manager's professional title and signature.	Case management documentation should contain the case manager's professional title and signature.	N: # of client charts with documentation reflecting the case manager's professional title and signature. D: # of client charts in the measurement year.	Client chart review
Obtain assurances and documentation showing that case management staff is operating as part of the clinical care team.	Percent of case managed client charts that had documentation showing that case management staff is operating as part of the clinical care team.	N: # of case managed client charts that had documentation showing that case management staff is operating as part of the clinical care team in the measurement year. D: # of case managed clients in the measurement year.	Client chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
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: # of staff with credentials and/or evidence of training of health care staff providing case management services in the measurement year. D: # of staff providing case management services in your Ryan White Part B program within your district in the measurement year.	Client chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
ADAP Performance Measures			
All ADAP clients must recertify for ADAP every 6 months. Note: Verifying Medicaid status is part of ADAP policy.	ADAP enrollment sites have systems to track ADAP client recertification due dates. Percent of eligible ADAP applicants who successfully recertified according to their recertification due date.	System to track ADAP recertification. N: # of ADAP clients who are reviewed for continued ADAP eligibility in the measurement period. D: # of ADAP clients in the measurement period.	Review of ADAP recertification tracking systems. Client record review Custom report from CAREWare. Georgia Health Partnership Portal to verify Medicaid eligibility.
Local ADAP enrollment site representatives will submit correctly completed ADAP applications to the State ADAP Office.	Percent of correctly completed ADAP applications submitted to ADAP Office during the reporting period.	N: # of correctly completed ADAP applications submitted to ADAP during the reporting period. D: # 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: # of ADAP applications sent back to ADAP enrollment sites for a specified deficiency. D: # of ADAP applications submitted to State ADAP Office during the reporting period.	Custom reports from CAREWare.
State ADAP Office will approve or deny clients for ADAP services within 2 weeks of receiving a complete ADAP application.	Percent of new ADAP applications approved or denied for ADAP enrollment within 2 weeks of ADAP receiving a complete application during the reporting period.	N: # of applications that were approved or denied within 2 weeks of ADAP receiving a complete application during the reporting period. D: # of complete applications received during the reporting period.	Custom reports from CAREWare.

Criteria	Indicators	Data Elements	Data Sources & Methods
Local ADAP enrollment site representatives must inform the State ADAP Office when a client discontinues or terminates ADAP services. Clients are discontinued from ADAP services if the client has not picked-up medications for 60 or more consecutive days and/or if the client has not recertified within the last 6 months.	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. Client chart review
ADAP clients will receive appropriate antiretroviral (ARV) regimens.	Percent of identified inappropriate ARV regimen or component prescriptions that are reviewed and resolved by ADAP during the measurement year.	N: # of ARV regimens or component prescriptions listed in the Table, "Antiretroviral Regimens or Components that Should Not Be Offered At Any Time," of the DHHS ART guidelines that are reviewed and resolved by ADAP during the measurement year. D: # of inappropriate ARV regimen or components that are prescribed and funded by ADAP.	PBM reports – in process. ACP Network On-Site Audits.

Criteria	Indicators	Data Elements	Data Sources & Methods
ADAP will conduct an internal audit of new client applications quarterly to determine if the applications and recertification's are completed and approved or denied according to ADAP policies and procedures.	Percent of ADAP new client application forms that were correctly completed during the quarter.	N: # of ADAP new client applications that were correctly completed during the reporting period. D: # of ADAP new client applications reviewed during the reporting period.	Internal audit of ADAP new client applications.
Clinical Performance Measures – General			
HIV-infected clients will receive ongoing risk reduction counseling as part of their medical care.	Percent of HIV-infected clients who received HIV risk counseling within the measurement year.	N: # of HIV-infected clients in the denominator who received HIV risk counseling as part of their medical care. D: # of HIV-infected clients who had at least one medical visit[1] with a provider with prescribing privileges in the measurement year.	CAREWare
HIV-infected clients will receive substance use screening when they initiate primary medical care.	Percent of new clients with HIV infection who have been screened for substance use (alcohol and drugs) in the measurement year.	N: # of HIV-infected clients in the denominator who were screened for substance use within the measurement year. D: # of HIV-infected clients who were new during the measurement year, and had a medical visit[1] with a medical provider with prescribing privileges at least once in the measurement year.	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
HIV-infected clients will receive mental health screening when they initiate primary care.	Percent of new clients with HIV infection who have had a mental health screening.	N: # of HIV-infected clients in the denominator who received a mental health screening. D: # of HIV-infected clients who were new during the measurement year, and had a medical visit[1] with a provider with prescribing privileges at least once in the measurement year.	CAREWare
Clinical Performance Measures – Dental Exams			
HIV-infected clients will receive an oral examination by a dentist at least annually.	1) Percent of HIV-infected clients who received an oral examination by a dentist at least once in the measurement year. 2) Percent[6] of HIV-infected clients who received an oral examination by a dentist or dental hygienist at least once in the measurement year.	1) N: # of HIV-infected clients in the denominator who had an oral exam by a dentist in the measurement year[2]. D: # of HIV-infected clients who had at least one medical visit[1] with a provider with prescribing privileges at once during the measurement year. 2) N: # of HIV-infected clients in the denominator who had an oral exam by a dentist or dental hygienist in the measurement year.[4] D: # of HIV-infected clients who had at least one medical visit[5] with a provider with prescribing privileges during the measurement year.	CAREWare Clinical chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
Clinical Performance Measures – Medical Visits			
Gap in HIV medical visits - Percent of clients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6-months of the measurement year.	Percent[6] of clients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6-months of the measurement year.	1) N: # of clients in the denominator who did not have a medical visit in the last 6-months of the measurement year. D: # of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit[1] in the first 6-months of the measurement year, excluding clients who died at any time during the measurement year. 2) N: # of clients in the denominator who did not have a medical visit in the last 6-months of the measurement year. D: # of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit[5] in the first 6-months of the measurement year, excluding clients with documentation that client no longer receiving care (i.e., deceased, transferred, lost to follow-up, etc.) at any time during the measurement year.	CAREWare Clinical chart review

Medical visit frequency - Percent of clients, regardless of age, with a diagnosis of 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[6] of clients, regardless of age, with a diagnosis of 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: # of clients 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: # of clients, regardless of age, with a diagnosis of HIV with at least one medical visit[1] in the first 6-months of the 24- month measurement period, excluding clients who died at any time during the 24-month measurement period. 2) N: # of clients 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: # of clients, regardless of age, with a diagnosis of HIV with at least one medical visit[5] in the first 6-months of the 24- month measurement period,	CAREWare Clinical Chart Review

Criteria	Indicators	Data Elements	Data Sources & Methods
		excluding clients with documentation that client no longer receiving care (i.e., deceased, transferred, lost to follow-up, etc.) at any time during the measurement period.	
Clinical Performance Measure – HIV Viral Loads			
HIV-infected clients should have viral load repeated every 3-4 months or as clinically indicated to confirm continuous viral suppression. Clinicians may extend the interval to 6 months for adherent, stable clients whose viral load has been suppressed for more than 2 years.	Percent[6] of clients, regardless of age, with a diagnosis of HIV with a viral load test performed at least every 6 months during the measurement year.	N: # of clients in the denominator with a viral load test performed every 6 months. D: # of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit[5] during the measurement year excluding clients with documentation that client 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 clients, regardless of age, 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.	Percent[6] of clients, regardless of age, 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: # of clients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. D: # of clients, regardless of age, with a diagnosis of HIV with 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[6] of new clients (first visit within the review year) who had resistance testing performed before the initiation or re-initiation of ART.	N: # of clients in the denominator on whom resistance testing was performed before the initiation or re-initiation of ART. D: Number of new clients with a diagnosis of HIV with at least one medical visit[5] in the measurement year and prescribed ART.	Clinical chart review
Prescription of ART - Percent of clients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year.	Percent[6] of clients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year.	N: # of clients in the denominator prescribed HIV antiretroviral therapy during the measurement year. D: # of clients, regardless of age, with a diagnosis of HIV with at least one medical visit[1,5] in the measurement year.	CAREWare Clinical chart review
HIV-infected clients will receive appropriate antiretroviral (ARV) regimens, based on current DHHS guidelines.	Percent[6] of HIV-infected clients on ARV according to Department of Health and Human Services (DHHS) antiretroviral treatment guidelines in the measurement year.	N: # of clients in the denominator on ARV according to DHHS guidelines in the measurement year. D: # of HIV-infected clients on ARV and who had at least one medical visit[5] in the measurement year.	Clinical chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
All HIV-infected pregnant females should receive ART, to prevent perinatal transmission as early in pregnancy as possible.	Percent[6] of HIV-infected pregnant females who were prescribed ART.	N: # of HIV-infected pregnant female clients in the denominator who were prescribed ART. D: # of HIV-infected pregnant female clients who had at least one medical visit[1,5] during the measurement year.	CAREWare Clinical chart review
HIV-infected clients will have fasting lipids evaluated at least annually.	1) Percent of HIV-infected clients, regardless of age, on ART who had a fasting lipid panel in the measurement year. 2) Percent[6] of HIV-infected clients, regardless of age, who had a fasting lipid panel in the measurement year.	1) N: # of clients in the denominator who had a fasting lipid panel in the measurement year. D: # of HIV-infected clients, regardless of age on ART who had at least one medical visit[1] during the measurement year. 2) N: # of clients in the denominator who had a fasting lipid panel in the measurement year. D: # of HIV-infected clients, regardless of age, who had at least one medical visit[5] during the measurement year.	CAREWare Clinical chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
Clinical Performance Measures – Pap Smears and Sexually Transmitted Infection (STI) Screening			
HIV infected female clients should commence receiving Pap smears within 1 year of the onset of sexual activity regardless of mode of HIV transmission (e.g., sexual activity, perinatal exposure) but no later than 21 years old.	1) Percent of HIV-infected female clients who were screened for cervical cancer in the last three years. 2) Percent[6] of HIV-infected female clients who received a Pap smear per DHHS guidelines.	1) N: # of HIV-infected female clients in the denominator who were screened for cervical cancer in the last three years. D: # of HIV-infected female clients 21 years or older in the measurement year and who had at least one medical visit with a provider with prescribing privileges[1]. (excludes client with hysterectomy for non-dysplasia/non-malignant indications). 2) N: # of HIV-infected female clients in the denominator who had Pap smear documentation, per DHHS guidelines, in the measurement year. D: # of HIV-infected female clients 18 years or older or who reported sexual activity and had at least one medical visit[5] during the measurement year. (excludes women with hysterectomy for benign reason).	CAREWare Clinical chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
All female clients with abnormal Pap smear results will have documentation for diagnostic evaluation.	Percent[6] of HIV-infected female clients with abnormal Pap smear results having documentation for diagnostic evaluation (e.g., repeat cytology in 6 to 12 months for ASC-US without HPV testing, colposcopy plus biopsy, etc.).	N: # of HIV-infected female clients in the denominator with abnormal Pap smear results having documentation for diagnostic evaluation. D: # of HIV-infected female clients 18 years or older or who reported sexual activity and had at least one medical visit[5] during the measurement year. (excludes women with hysterectomy for benign reason) with abnormal Pap smear results.	Clinical chart review
HIV-infected clients at risk for an STI will be screened for chlamydia at least annually.	Percent of clients with HIV infection at risk for STIs who had a test for chlamydia within the measurement year.	N: # of HIV-infected clients in the denominator who had a test for chlamydia. D: # of HIV-infected clients who were either newly enrolled in care, sexually active, or had an STI within the last 12 months, and had a medical visit[1] with a provider with prescribing privileges at least once in the measurement year.	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
HIV-infected clients at risk for an STI will be screened for gonorrhea at least annually.	Percent of clients with HIV infection at risk for STIs who had a test for gonorrhea within the measurement year.	N: # of HIV-infected clients in the denominator who had a test for gonorrhea. D: # of HIV-infected clients who were either newly enrolled in care, sexually active, or had an STI within the last 12 months, and had a medical visit[1] with a provider with prescribing privileges at least once in the measurement year.	CAREWare
HIV-infected clients will be screened for syphilis at least annually.	Percent[6] of HIV-infected clients who were screened for syphilis in the measurement year.	N: # of HIV-infected clients in the denominator who had a serologic test for syphilis performed in the measurement year. D: # of HIV-infected clients 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 – Tuberculosis (TB), and Hepatitis Screening			
HIV-infected clients 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 HIV-infected clients with documentation of TB screening test performed and results interpreted at least once since the diagnosis of HIV infection.	1) N: # of clients in the denominator who had documentation that a TB screening test was performed and results interpreted at least once since diagnosis of HIV infection. D: # of HIV-infected clients who had at least two medical visits[1] during the measurement year, with at least 90 days in between each visit, excluding clients with documentation of medical reason for not performing TB screening test.	CAREWare
	2) Percent[6] of HIV-infected clients who completed TB screening (i.e., had a TST placed and interpreted within 48 to 72 hours, or Interferon-Gamma Release Assay (IGRA) performed) at least once since diagnosis of HIV.	2) N: # of clients in the denominator who had TB screening test performed and results interpreted at least once since diagnosis of HIV infection. D: # of HIV-infected clients with at least one medical visit[5] in the measurement year, excluding clients with documentation of a medical reason for not performing TB screening test.	Clinical chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
All HIV-infected clients will be screened for Hepatitis B at least once since HIV diagnosis, unless there is documented infection or immunity.	Percent of clients, regardless of age, for whom Hepatitis B screening was performed at least once since the diagnosis of HIV/AIDS or for whom there is documented infection or immunity.	1) N: # of clients in the denominator for whom Hepatitis B screening was performed at least once since the diagnosis of HIV or for whom there is documented infection or immunity. D: # of clients, regardless of age, with a diagnosis of HIV and who had at least two medical visits[1] during the measurement year, with at least 60 days in between each visit.	CAREWare
All HIV-infected clients must be screened for Hepatitis C virus (HCV) at least once after HIV diagnosis.	Percent[6] of HIV-infected clients for whom HCV screening was performed at least once since HIV diagnosis.	N: # of HIV-infected clients in the denominator with documentation of HCV status. D: # of HIV-infected clients who had at least one medical visit[1,5] during the measurement year.	CAREWare Clinical chart review
Clinical Performance Measures – Hepatitis, Influenza and Pneumococcal Vaccination			
All HIV-infected clients 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 clients with HIV infection who completed the vaccination series for Hepatitis B.	1) N: # of HIV-infected clients in the denominator with documentation of having ever completed the vaccination series for Hepatitis B. D: # of HIV-infected clients who had a medical visit[1] with a provider with prescribing privileges at least once in the measurement year, excluding clients newly enrolled during the	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
	2) Percent[6] of clients with HIV infection who completed the vaccination series and antibody assessment for Hepatitis B according to DHHS Guidelines	measurement year, or with evidence of current infection or immunity. 2) N: # of HIV-infected clients in the denominator with documentation of having completed the vaccination series and antibody assessment for Hepatitis B per DHHS Guidelines. D: # of HBV susceptible HIV-infected clients who had a medical visit[5] with a provider with prescribing privileges at least once in the measurement year, excluding clients newly enrolled during the measurement year, or with valid contraindications or client refusals.	Clinical chart review
All HIV-infected clients without valid contraindications should receive the influenza vaccine annually.	Percent[6] of clients with HIV infection who have received influenza vaccination within the measurement period.	1) N: # of HIV-infected clients in the denominator who received influenza vaccination or who reported[2] receipt of influenza vaccination during the current season. D: # of HIV-infected clients who had a visit[1] between October 1st and March 31st of the measurement year, excluding clients with documentation of valid reasons to defer the vaccine (contraindications, client refusals, system reasons).	CAREWare Clinical chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
		2) N: # of HIV-infected clients in the denominator with documentation of receipt of influenza vaccination in the current season. D: # of HIV-infected clients who had a medical visit[5] with a provider with prescribing privileges in the measurement year, and whose first visit was before April 1st excluding clients with documentation of valid reasons to defer influenza vaccine (contraindications, client refusal).	
All HIV-infected clients without valid contraindications, should receive the pneumococcal vaccine.	Percent of clients with HIV infection who ever received pneumococcal vaccine.	N: # of HIV-infected clients in the denominator who ever received pneumococcal vaccine. D: # of HIV-infected clients who had a medical visit[1] with a provider with prescribing privileges at least once in the measurement year, excluding clients with CD4 counts < 200 cell/mm³ within the measurement year.	CAREWare
Clinical Performance Measures – Opportunistic Infection Prophylaxis			
All HIV-infected clients with CD4 counts below 200 cells/mm^3 should receive chemo-prophylaxis against *Pneumocystis* pneumonia (PCP).	Percent[6] of HIV-infected clients who were prescribed PCP prophylaxis.	1) N: # of HIV-infected clients in the denominator with CD4 counts below 200 cells/mm^3 who were prescribed PCP prophylaxis.	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
		D: # of HIV-infected clients with CD4 counts below 200 cells/mm^3 and who had at least two medical visits[1] during the measurement year, with at least 90 days between visits, excluding clients who did not receive PCP prophylaxis because there was a CD4 count above 200 cell/mm^3 during the three months after a CD4 count below 200 cells/mm^3. 2) N: # of HIV-infected clients in the denominator with CD4 counts below 200 cells/mm^3 who were prescribed PCP prophylaxis. D: # of HIV-infected clients with CD4 counts below 200 cells/mm^3 and who had at least one medical visits[5] during the measurement year, excluding clients who did not receive PCP prophylaxis because there was a CD4 count above 200 cell/mm^3 during the three months after a CD4 count below 200 cells/mm^3 or documented CD4 count 100-200 cells/mm^3 and HIV RNA remain below limit of detection for at least 3-6 months	Clinical chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
All HIV-infected clients with CD4 counts below 50 cells/mm^3 should receive chemo-prophylaxis against *Mycobacterium avium* complex (MAC).	Percent[6] of HIV-infected clients with CD4 counts below 50 cells/mm^3 who were prescribed MAC prophylaxis in the measurement year.	N: # of HIV-infected clients in the denominator with CD4 counts below 50 cells/mm^3 who were prescribed MAC prophylaxis. D: # of HIV-infected clients with CD4 counts below 50 cells/mm^3 and who had at least one medical visit[1,5] during the measurement year, excluding clients with disseminated MAC.	CAREWare Clinical chart review

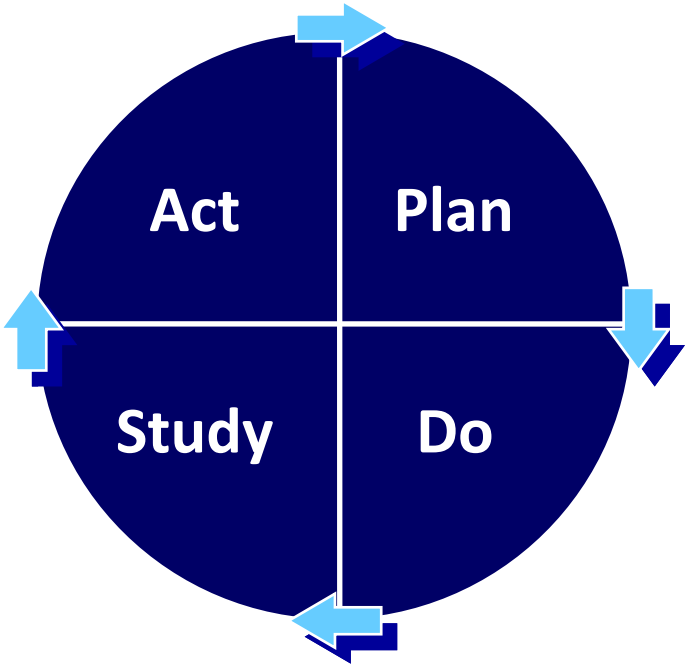
[1]CAREWare - Medical visit data is from Outpatient/Ambulatory Medical Care may include primary care, lab, medication pick up, etc.
[2]CAREWare - client self-report limitations.
[4]Client self-report not accepted.
[5]Chart review - medical visit with a prescribing provider before November 1st of measurement year.
[6]Clinical chart review percent is weighted average.

Appendix F
Model for Improvement

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?

PDSA Cycles



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

From the HAB/NQC Ryan White Program Part B Collaborative, LS1,
National Quality Center (NQC)

Date: _Cycle#:_____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*)

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?

Appendix G
Clinical QM Plan Approval

FY2018-2019 CQM Plan and Work Plan Approval

The FY**2018-2019** RW Part B CQM Plan and Work Plan are approved by the following:

Ryan White Part B QM Core Team

Date

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

Date

William Lyons, HIV Office Director
Georgia Department of Public Health

Date

Georgia Department of Public Health
Division of Health Protection
Office of HIV/AIDS