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I. Introduction

About this Document

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

The Georgia RW Part B Program CQM Plan is outlined in this document. This document is considered a “living” document and revisions may be made as the Georgia Department of Public Health (DPH), Division of Health Protection, Office of HIV/AIDS continues to develop and expand the RW Part B CQM Program and Plan. This Plan is effective April 1, 2019 to March 31, 2020. A timeline for annual implementation, revision, and evaluation of the Plan is in Appendix B of this document. Any questions regarding this plan, may be directed to the RW Part B Program CQM Team: Sandra Metcalf (404) 657-3113 or Takiyah Turks (404) 651-5131.

Ryan White Overview

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, now the Ryan White HIV/AIDS Treatment Extension Act of 2009 is a Federal legislation that addresses the unmet health needs of persons living with HIV (PLWH) 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. For FY2019 total Ryan White CARE Act funding was \$2.3 billion.

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. Sub-recipients 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 Part B Clinical Quality Management Program is to ensure the highest quality of medical care and supportive services for people living with HIV/AIDS in Georgia.

B. Vision

The vision of the CQM 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 sub-recipients by monitoring core performance measures across RW Part B program sub-recipients
- 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 sub-recipients provide primary care services. Support services are funded based on the availability of resources. The Ryan White Part B Program also funds the Georgia ADAP and HICP, which provides medication for the treatment of HIV/AIDS to eligible participants or assists with health insurance premiums and co-pays.

The primary role of sub-recipients, also referred to as sub-recipients, 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 Part B Program 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 Part B program grant. The Office of HIV/AIDS Director provides leadership and coordination of HIV care and prevention activities. The Office of HIV/AIDS leadership is dedicated to the quality improvement process and guides the CQM Plan. The HIV Care Manager is responsible for ensuring administration of the grant, including the development and implementation of the CQM Plan.

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) Part B Program Sub-Recipients

- RW Part B Sub-recipients are responsible for ensuring quality management components of the Grant-in-Aid and contractual agreements are met. The FY2019-2020 CQM deliverables include the following language, as referenced in the Georgia RW Part B/ADAP/HICP Policies and Procedures: Sub-recipients are expected to refer to the Georgia Ryan White 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.

Sub-recipients 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), advanced practice registered nurses (APRN), 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, HIV-Infected Adult (current edition).
- Georgia Department of Public Health, Prescriptive Authority for Advanced Practice Registered Nurses Toolkit (current edition).
- Georgia Department of Public Health Policy #PT-18001, Georgia ADAP and APRN Prescriptive Authority for Nurses Not Employed by Public Health Policy and Procedure (current edition).
- Georgia Department of Public Health Policy #PT-18002, Georgia AIDS Drug Assistance Program Physician Assistant Provider Status Policy and Procedure (current edition).
- Compliance with United States Department of Health and Human Services (DHHS) HIV-related 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 CQM Program according to HRSA’s HIV/AIDS Bureau (HAB) expectations for Ryan White recipients. Include the following:
 - A written CQM Plan, which is updated annually
 - Project-specific continuous quality improvement (CQI) plan (e.g., work plan)
 - A leader and team to oversee the CQM Program
 - CQM 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 CQM Program.
- Monitor performance measures as determined by the Part B CQM Program.
- Participate in HIV clinical and case management chart reviews conducted by state office CQM staff.
- Provide CQM plans, reports (to include CQI activities), and other information related to the local CQM Program as requested by the Office of HIV/AIDS Ryan White Part B District Liaison and/or CQM staff. Allow the District Liaison and/or CQM staff access to all CQM information and documentation.

- Ensure compliance with the Georgia Ryan White Part B Case Management Standards (current edition).

B. Clinical Quality Management Committee(s)

1. Quality Management Core Team

a. Purpose

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

b. Membership

- The Core Team membership will be reviewed annually and changes made accordingly.
- Each RW Part B Program sub-recipient must identify one person and an alternate to represent their district. The person identified will become an active member of the CQM 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 CQM Core Team. The consumer does not represent a particular district, but rather represents consumers who have access to RW Part B Program services. Consumers are selected as needed following submission of candidates.

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 CQM 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 CQM 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 (CQM Team Leader). Duties include:
 - Supervise the CQM Team
 - Coordinate day-to-day CQM Program operations and meetings
 - Coordinate systems-level CQI projects
 - Ensure development, implementation, and evaluation, of the CQM Plan and Work Plan
 - Ensure revision of the CQM Plan at least annually, and the Work Plan at least quarterly
 - Oversee the submission of required reports related to CQM to upper management
 - Coordinate and ensure CQM/CQI and other HIV-related training is available
 - Closely monitor assigned sub-recipients' plans and quarterly reports
 - Oversee technical assistance provision to RW Part B Program sub-recipients by staff (i.e. development of local CQM plans, nursing/clinical services and case management)
 - Coordinate site visits to review CQM plans and activities and/or 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/policies 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 CQM Program:
 - Plan meetings and/or conference calls
 - Communicate with the Core Team and subcommittees
 - Complete reports and other assignments
 - Participate in systems-level CQI projects
 - Participate on the CQM Core Team
 - Closely monitor assigned sub-recipients' CQM plans and quarterly reports
 - Provide technical assistance to RW Part B Program sub-recipients in the development of local CQM plans and activities
 - Conduct site visits to review CQM plans and activities and/or clinical performance indicators
 - Coordinate revisions of nurse protocols
 - Develop or revise medical guidelines, policies, 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 CQM 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 CQM Core Team
- Ensure development, implementation, and evaluation of statewide case management standards and tools
- Ensure CQM/ CQI and case management training is available
- Assist with revision of the CQM Plan and Work Plan
- Closely monitor assigned sub-recipients' CQM plans and quarterly reports
- Provide technical assistance to the RW Part B Program sub-recipients in the development of local CQM plans and activities
- Conduct site visits to review CQM 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 CQM Core Team
 - Provide medical expertise and technical assistance to the Office of HIV/AIDS, ADAP, RW Part B Program sub-recipients 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 CQM-related reports and assignments
- Assist with development and/or revisions of medical guidelines, policies, 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 CQM 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)/Health Insurance Continuation Program (HICP) Manager – Duties include:
 - Manage and coordinate ADAP/HICP and all related components of the CQM plan including CQI projects and performance measures
 - Facilitate the ADAP/HICP Workgroup
 - Ensure CQM/CQI findings/reports are shared regarding systems-level CQI projects.
 - Attend educational conferences or other events sponsored by HRSA, DPH, GA AETC, professional organizations or other appropriate sponsoring organizations to maintain current knowledge of HIV clinical practice and/or Quality Management
- ADAP Pharmacy Director – Duties include:
 - Supervise the ADAP Business Operations Specialist
 - Provide HIV and Hepatitis C medication management training and educational resources for the ADAP Contract Pharmacy (ACP) Network
 - Oversight and monitoring of daily ADAP pharmacy operations for the ACP Network
 - Oversight and monitoring of ADAP contract pharmacy on-site audits and visits to review contract compliance including antiretroviral therapy management and dispensing
 - Pharmaceutical-related system improvements of ADAP and the ACP Network

- Provide pharmacy expertise and TA to the Office of HIV/AIDS, ADAP, Part B sub-recipients and others
- Participate on the HIV Medical Advisory Committee
- Participate in the revision of the HIV/AIDS-related nurse protocols
- Ensure CQM/QI findings/reports are shared regarding systems-level CQI projects
- Develop and revise HIV-related medication guidelines and other guidelines/policies 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 sub-recipient staff
 - Create custom reports to collect performance measure data.
 - Generate CAREWare reports
 - Delegate duties to CAREWare staff as needed

Other CQM 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 Part B Program sub-recipients (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 CQM activities align with sub-recipient CQM plan/activities

- Representatives from RW Program Parts A, C, and D – Duties include:
 - Represent their agencies/programs and ensure that Part B CQM activities align across RW Programs statewide
- Medicaid Representative (Ad hoc) – Duties include:
 - Assist with Medicaid-related CQM activities as needed
- Representative from HIV Prevention – Duties include:
 - Provide updates on HIV Prevention activities 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 Part B Program Office of HIV/AIDS staff – Duties include:
 - Participate in activities of the CQM Plan as needed. (See Appendix C for 2018-2019 Core Team Members)

c. Communication

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

d. General Core Team Responsibilities

- A Nurse Consultant serves as the key contact and team leader for clinical quality management.
- At least one member of the CQM 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 CQM Program including determining priorities, setting goals, creating/revising the work plan (see Appendix A), preparing reports, and evaluating the program and plan.
- The Core Team:
 - Determines the need for subcommittees and guides the subcommittee's work plan
 - Actively participates in meetings, conference calls, and other activities as needed

- Determines performance measures, and identifies indicators to assess and improve performance
- Shares findings with the Office of HIV/AIDS, RW Part B Program sub-recipients/consortia, DPH leadership and others
- Reviews and updates the CQM 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 CQM 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 Part B Program 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 Part B Program 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 committee needs to be called into session. (See Appendix C for committee members.)
- **Responsibilities:**

- Comply with the Core Team's overall goals and Work Plan
- Actively communicate with the 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 CQM 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 CQM Core Team as appropriate
 - Systematize changes if appropriate

4. Local Sub-recipients and CQM Committees

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

C. Coordination with Other Statewide QI/QA Activities

1. Coordination across RW Programs

- a. The RW Part B Program CQM Plan focuses on collaboration of quality activities across all RW Parts in Georgia.
- b. The RW Part B Program CQM 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 CQM staff person attends the Metro Atlanta EMA QM Committee meetings. The Core Team collaborates across RW Programs on CQM 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. The Core Team includes an ad hoc member of the HIV/AIDS Surveillance Unit.
- c. 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.
- d. At least one member of the Core Team will participate on the Georgia Oral Health Coalition.
- e. 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 Part B Program CQM 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 CQM Workgroup meets as a subcommittee as needed and reports to the CQM Core Team.

4. Feedback from Key Stakeholders

- a. The Core Team communicates findings and solicits feedback from both internal and external key stakeholders, i.e., RW Part B Program Coordinators, consortia and RW Program meetings, on an ongoing basis.
- b. Written reports are shared with key stakeholders.
- c. Stakeholders are given the opportunity to provide feedback to reports and to prioritize quality activities.
- d. The Office of HIV/AIDS maintains current Part B CQM Plans, reports, and other related information on the Office's web pages.
- e. 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 Part B Program CQM staff participate in Center for Quality Improvement and Innovation (CQII) trainings and webinars to support their ongoing CQM skills development. This enables staff to provide and coordinate technical assistance/training for RW Part B Program sub-recipients. In addition, sub-recipients and the CQM Core Team are informed of CQII trainings and webinars.
- CQII training materials and resources are utilized as much as possible.
- CQM technical assistance/training needs are assessed through requests in sub-recipients applications, monitoring of local CQM plans/programs and quarterly reports, and through training evaluations and/or needs assessments.
- CQI Best Practices. Sub-recipients are selected to showcase best practices and/or success with improvement projects.

IV. Evaluation

A. Self-Assessment

- The CQM Core Team completes the *Organizational Assessment Tool for Ryan White HIV/AIDS Program-funded Part B Recipients* at least annually.
- The CQM 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 CQM Core Team completes an annual assessment and subsequent revision of the CQM plan.
- The CQM Core Team evaluates the RW Part B Program CQM Program on an annual basis including rating the completeness of strategies.

B. Evaluation of Local CQM Plans

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

C. External Evaluation

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

D. CQM Plan Evaluation

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

E. DPH Evaluation

- At least annually, findings are reported to leadership within DPH.
- A revised CQM 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-hiv-aids-epidemiology-surveillance-section>
- Ryan White Part B Service Standards
- Ryan White Programs Part C and D
- Other DPH personnel as needed
- Local sub-recipients
- 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	Dec 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%	82%
	<i>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.</i>			
	<i>Denominator: Number of participants, with at least one HIV medical provider visit in the measurement year.</i>			
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%	91%
	<i>Numerator: Number of participants from the denominator prescribed HIV antiretroviral therapy during the measurement year.</i>			
	<i>Denominator: Number of participants with at least one HIV medical provider visit in the measurement year.</i>			
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%	61%
	<i>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.</i>			
	<i>Denominator: Number of participants with at least one HIV medical visit in the first 6 months of the 24-month measurement period.</i>			
Gap in HIV Medical Visits	Percent of Ryan White Part B Program participants who did not have a HIV medical	17%	24%	17%

Georgia Ryan White Part B Care Program				
Performance Measure	Goal	Outcomes		
		Dec 2016	Dec 2017	Dec 2018
	provider visit in the last 6 months of the measurement year will be less than 16%.			
	<i>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.</i>			
	<i>Denominator: Number of participants who had at least one medical provider visit in the first 6 months of the measurement year.</i>			

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 sub-recipients
 - 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 Part B Program sub-recipients are required to report data on key performance indicators.
2. The Core Team reviews and compiles findings.
3. District Liaisons and/or Ryan White Part B Program CQM staff review sub-recipient CQM plans and reports for effectiveness and accuracy.
4. Findings are shared with RW Part B CQM Core Team, HIV providers, RW Part B Program sub-recipients, , the Office of HIV/AIDS, 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 sub-recipient reports include performance measures from the Part B Implementation Plan.
3. The HIV Nurse Consultants and Medical Advisor review RW Part B Program 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 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 Part B Program sub-recipients monitor selected performance measures and report to the Program. The Core Team reviews these measures and compiles reports.
5. RW Part B Program sub-recipients 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 RW Part B sub-recipient clinical and case management charts for performance measures (See Appendices D and E). Findings are summarized and reported back to each site with a request for improvement plan based on findings.
7. The QM Coordinator monitors Ryan White Part B sub-recipients for compliance with case management standards and performance measures.
8. The CQM Core Team annually assesses the CQM Program for effectiveness.

VII. Clinical Quality Management (CQM)

A. Quality Management Work Plan

- The CQM plan includes a “living” Work Plan that is updated at least quarterly.
- The Work Plan specifies objectives and strategies for CQM plan goals listed below in 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 CQM plan at least annually and the CQM work plan at least quarterly.

- 1.e. Require that all RW Part B Program sub-recipients revise written CQM plans/workplans annually and submit quarterly CQM progress reports to include continuous quality improvement (CQI) project updates.

Goal 2: Improve efficiency of the Georgia AIDS Drug Assistance Program (ADAP).

Objectives include:

- 2.a. Monitor viral load suppression among 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 sub-recipients.
- 4.b. Continue CQI project to analyze contributing factors related to the increased rate for Gap in Medical Visits.
- 4.c. Implement the *Georgia HIV/AIDS Case Management Standards*.
- 4.e. Participate in quality-related activities across Ryan White Programs (Parts A, B, C, and D) in Georgia.
- 4.f. The percent of pregnant women living with HIV prescribed antiretroviral therapy will be 95% or greater.
- 4.g. Monitor, assess and improve perinatal systems of care for women living with HIV and their infants.
- 4.h. Continue statewide CQI Project with the aim to increase Consumer involvement in sub-recipients and state level CQM 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 Communities (EC) and Minority AIDS Initiative (MAI) program requirements.

C. Quality Management Plan Timeline

- The CQM plan includes a timeline to ensure annual revision of the CQM plan.
- The timeline incorporates development, implementation, and revision of the plan based on the Ryan White Part B Program grant year.
- The timeline includes quarterly CQM Core Team meetings 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 CQM Core Team and/or the Office of HIV/AIDS Care Team select and prioritize statewide or system CQI projects
- Data is utilized to guide project selection
- CQI Methodology is utilized and may include 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 CQM Work Plan
- Sub-recipient CQM plans include CQI projects
- Sub-recipients report progress on CQI projects quarterly

A. CQI Projects and Goals:

CQI projects are detailed in the CQM 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 CQM plan includes a “living” Work Plan that is updated at least quarterly.
2. The Work Plan specifies objectives and strategies for CQM Plan goals. (The Clinical Work Plan is attached in a separate file as Appendix A)
 - 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 CQM 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 2019-2020 Work Plan

Goal 1: Continuously implement a statewide RW Part B Program Clinical Quality Management (CQM) 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 based on identified needs.	<p>1-1.a. Plan and conduct quality management trainings based on identified needs.</p> <p>1-1.b. Share information on CQII training with CQI Core Team and sub-recipients.</p> <p>1-1.c. Share best practices during CQM Core Team meetings.</p> <p>1-1.d. Collaborate with partners to implement clinical and/or case management training based on identified needs.</p>	Sandra Metcalf, Takiyah Turks	<p>Part A</p> <p>HIV Qual Consultant</p> <p>Care Team</p>	<p>1-1.a. As needed</p> <p>1-1.b. As available</p> <p>1-1.c. Two times per year</p> <p>1-1.d. TBD</p>	
1-2 Assure that sub-recipients conduct at least one quality improvement project each year.	<p>1-2.a. Facilitate system improvements by utilizing CQI methodologies.</p> <p>1-2.b. Review local CQI projects and provide technical assistance (TA).</p>	Sandra Metcalf, Takiyah Turks	<p>Care Team</p> <p>Training materials and</p>	<p>1-2.a. Quarterly</p> <p>1-2.b. Quarterly</p>	

	<p>1-2.c. Meet with and provide onsite TA to local CQM committees.</p> <p>1-2.d. Monitor sub-recipients quarterly CQM reports for CQI and best practices.</p> <p>1-2.e. Showcase CQI best practices.</p> <p>1-2.f. Share updates and solicit input from CQM Core Team regarding statewide improvement efforts.</p>		<p>assessment tools</p> <p>District Liaisons</p> <p>Local Committees</p>	<p>1-2.c. As needed</p> <p>1-2.d. Quarterly</p> <p>1-2.e. TBD</p> <p>1-2.f. Quarterly</p>	
<p>1-3 Communicate findings to key stakeholders at least biannually.</p>	<p>1-3.a. Present at Statewide Part B Meetings and other applicable meetings.</p> <p>1-3.b. Share progress reports with all Parts and across programs as appropriate, specifically share work plans with progress notes completed.</p> <p>1-3.c. Update CQM information on the Office of HIV/AIDS web page.</p> <p>1-3.d. Explore strategies to involve sub-recipients in the statewide quality process.</p>	<p>Sandra Metcalf, Takiyah Turks</p>	<p>CQM Core Team</p> <p>Care Team</p>	<p>1-3.a. TBD</p> <p>1-3.b. Quarterly</p> <p>1-3.c. As needed</p> <p>1-3.d. As needed</p>	
<p>1-4 Update the CQM plan at least annually and the CQM work plan at least quarterly.</p>	<p>1-4.a. Revise work plan quarterly.</p> <p>1-4.b. Share CQM Plan with DPH and Office of HIV/AIDS stakeholders.</p> <p>1-4.c. Place revised CQM plan on Office of HIV/AIDS web pages.</p>	<p>Sandra Metcalf, Takiyah Turks</p>	<p>CQM Core Team</p> <p>Care Team</p>	<p>1-4.a. Quarterly</p> <p>1-4.b. Annually</p> <p>1-4.c. Annually</p>	

<p>1-5 Require that all RW Part B Program sub-recipients revise written CQM plans/work plans annually and submit quarterly CQM progress reports to include CQI project updates.</p>	<p>1-5.a. Obtain quarterly CQM reports from the Part B sub-recipients and monitor CQM activities (CQI project updates), work plan and PMs.</p> <p>1-5.b. Review revised CQM plans from each Part B funded agency.</p> <p>1-5.c. Provide feedback on local CQM plans to the funded health agency.</p>	<p>Sandra Metcalf, Takiyah Turks</p> <p>District Liaisons</p>	<p>District HIV Coordinators and Local CQM Committees</p> <p>CQM Core Team</p>	<p>1-5.a. Quarterly</p> <p>1-5.b. Per annual renewal date</p> <p>1-5.c. Per annual renewal date</p>	

Goal 2: Improve efficiency of the Georgia AIDS Drug Assistance Program (ADAP).

Objectives	Strategies	Lead	Staff Resources	Timeline	Progress Notes
<p>2-1 Monitor viral load suppression among Ryan White Part B ADAP program participants and maintain viral load suppression at 80% or greater.</p>	<p>2-1.a. Create quarterly report from the CAREWare database</p> <p>2-1.b. Review ADAP clients who adhere to at least 2 visits for routine HIV medical care in 12 months</p> <p>2-1.c. Utilize the reports to communicate with the district and enrollment staff</p> <p>2-1.d. Share finding with GA ADAP/HICP CQM Workgroup</p>	<p>Satin Francis</p>	<p>Satin Francis</p> <p>Alysia Johnson</p> <p>Data CAREWare Team</p>	<p>2-1.a. Quarterly</p> <p>2-1.b. Quarterly</p> <p>2-1.c. Quarterly</p> <p>2-1.d. Quarterly</p>	
<p>2-2 Monitor medical visit frequency among Ryan White Part B ADAP program participants and maintain at least 2 medical visits within 12 months.</p>	<p>2-2.a. Monitor medical visits within 12 month period.</p> <p>2-2.b. Create quarterly report from CAREWare monitoring medical visit frequency among Ryan White Part B ADAP program participants.</p> <p>2-2.c. Share findings and solicit input from CQM Core Team regarding statewide improvement efforts if needed.</p> <p>2-2.d. Utilize report to communicate with district and agency staff</p>	<p>Satin Francis</p>	<p>Satin Francis</p> <p>Alysia Johnson</p> <p>Data CAREWare Team</p>	<p>2-2.a. Quarterly</p> <p>2-2.b. Quarterly</p> <p>2-2.c. Quarterly</p> <p>2-2.d. Quarterly</p>	

	regarding client’s medical visit frequency.				
2-3 Increase the percent of new ADAP applications approved or denied for ADAP enrollment within 2 weeks of ADAP receiving a complete application to 95% or greater.	<p>2-3.a. Generate monthly reports to monitor this objective and share quarterly with the ADAP/HICP Subcommittee.</p> <p>2-3.b. Evaluate reports for trends in ADAP Office of HIV/AIDS performance in processing new applications.</p> <p>2-3.c. Conduct CQI projects to decrease length of time to determine ADAP eligibility or ineligibility by ADAP Office of HIV/AIDS.</p> <p>2-3.d. Utilize reports to communicate with district and agency staff regarding their rates of correctly completed ADAP application submissions.</p> <p>2-3.e. Provide technical assistance on ADAP applications and required supporting documentation to staff and agencies.</p> <p>2-3.f. Ensure that ADAP coordinators and case managers comply with the approved Georgia Ryan White Part</p>	Satin Francis, Alysia Johnson, and CAREWare Data Team	Case Management Program Consultant ADAP Team	<p>2-3.a. Monthly, quarterly</p> <p>2-3.b. Quarterly</p> <p>2-3.c. As needed</p> <p>2-3.d. Quarterly</p> <p>2-3.e. As needed</p> <p>2-3.f. During internal review as needed</p> <p>2-3.g. As needed</p> <p>2-3.h. As needed</p> <p>2-3.i. As needed</p>	

	<p>B/ADAP/HICP Policies and Procedures.</p> <p>2-3.g. Provide or coordinate ADAP-related training for ADAP/ HICP Enrollment Site Coordinators and case manager.</p> <p>2-3.h. Communicate GA ADAP updates via conference calls, email listserv, and Office of HIV/AIDS web pages.</p> <p>2-3.i. Convene the Georgia ADAP/HICP Quality Management Subcommittee as needed.</p>				
<p>2-4 Monitor the percent of Georgia ADAP clients who recertify semi-annually.</p>	<p>2-4.a. Generate monthly reports to monitor this objective and share quarterly with the ADAP/HICP Subcommittee.</p> <p>2-4.b. Utilize reports to communicate with district and agency staff regarding clients' recertification status.</p> <p>2-4.c. Monitor the ADAP enrollment sites systems to track ADAP client recertification due dates.</p> <p>2-4.d. Provide technical assistance to those who need assistance developing</p>	<p>Satin Francis, Alysia Johnson, and CAREWare Data Team</p>	<p>Case Management Program Consultant ADAP Team</p>	<p>2-4.a. Monthly, quarterly 2-4.b. Monthly. 2-4.c. During admin. site visits as needed 2-4.d. As needed</p>	

	<p>or improving their system to track ADAP client recertification due dates.</p> <p>2-4.e. Ensure that ADAP coordinators and case managers comply with the approved Georgia ADAP Policies and Procedures manual.</p> <p>2-4.f. Provide or coordinate ADAP related training for ADAP/ HICP Enrollment Site Coordinators and case managers.</p> <p>2-4.g. Conduct administrative site visits.</p> <p>2-4.h. Communicate GA ADAP updates via conference calls, email listserv and Office of HIV/AIDS web pages.</p> <p>2-4.i. Convene the Georgia ADAP/ HICP Quality Management Workgroup at least quarterly.</p> <p>2-4.j. Generate reports of the percent of discontinued clients enrolling in ADAP, and share quarterly with the ADAP/HICP Subcommittee.</p>			<p>2-4.e. During internal review as needed</p> <p>2-4.f. As needed on location or at the Office of HIV/AIDS</p> <p>2-4.g. Annually</p> <p>2-4.h. As needed</p> <p>2-4.i. As needed</p> <p>2-4.j. Monthly, quarterly</p>	
<p>2-5 Monitor ADAP applications for completeness.</p>	<p>2-5.a. Generate monthly reports to monitor this objective, and share</p>	<p>Satin Francis, Alysia Johnson, and</p>	<p>Case Management</p>	<p>2-5.a. Monthly</p>	

	<p>quarterly with ADAP/ HICP Workgroup.</p> <p>2-5.b. Utilize reports to communicate with district and agency staff regarding their rates of correctly completed new ADAP application submissions.</p> <p>2-5.c. Provide technical assistance on ADAP applications and backup documentation to staff and agencies as needed.</p> <p>2-5.d. Ensure that ADAP coordinators and case managers comply with the approved Georgia Ryan White Part B/ADAP/ HICP Policies and Procedures.</p> <p>2-5.e. Provide or coordinate ADAP related training for ADAP/ HICP Enrollment Site Coordinators and case managers as needed.</p> <p>2-5.f. Communicate GA ADAP updates via conference calls, email listserv, and Office of HIV/AIDS web pages.</p> <p>2-5.g. Convene the Georgia ADAP/ HICP Quality Management Workgroup as needed.</p>	<p>CAREWare Data Team</p>	<p>Program Consultant</p> <p>ADAP Team</p>	<p>2-5.b. Quarterly</p> <p>2-5.c. As needed</p> <p>2-5.d. During internal reviews as needed</p> <p>2-5.e. As needed</p> <p>2-5.f. As needed</p> <p>2-5.g. As needed</p>	
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<p>2-6 Conduct an internal audit of up to 5% of ADAP new client application forms annually.</p>	<p>2-6.a. Review complete audit of all active client files.</p> <p>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.</p> <p>2-6.c. For applications and forms that were incomplete, request and obtain required documentation.</p> <p>2-6.d. Create quarterly Report Card from CAREWare summarizing key findings.</p> <p>2-6.e. Share findings with ADAP district or agency enrollment sites.</p> <p>2-6.f. Share findings with the GA ADAP/HICP CQM Workgroup to initiate CQI projects as indicated.</p>	<p>Satin Francis and Alysia Johnson</p>	<p>ADAP Team</p> <p>CQM Team</p>	<p>2-6.a. Annually</p> <p>2-6.b. Daily</p> <p>2-6.c. As needed</p> <p>2-6.d. Quarterly</p> <p>2-6.e. Quarterly</p> <p>2-6.f. Quarterly</p>	
<p>2-7 Monitor programmatic compliance and adherence to antiretroviral regimens through the data collection system.</p>	<p>2-7.a. Instruct sub-recipients to utilize PBM reports to routinely monitor clients who pick up medications from the ACP Networks.</p> <p>2-7.b. Review PBM compliance/ adherence reports.</p>	<p>Gay Campbell</p>	<p>Gay Campbell</p> <p>Satin Francis</p> <p>Alysia Johnson</p>	<p>2-7.a. Quarterly</p> <p>2-7.b. Quarterly</p> <p>2-7.c. As needed</p>	

	<p>2-7.c. Provide medication adherence training to ADAP contract pharmacies.</p> <p>2.7.d. Conduct ACP Network audits.</p>			2-7.d As needed	
<p>2-8 Systematically review data collected by the ADAP to identify inappropriate antiretroviral therapy (ART) regimens or components.</p>	<p>2-8.a. Discuss with PBM how to best monitor for inappropriate ART regimens or components including the development of electronic reports and real time hard-halt adjudication rejections at pharmacy point of service if inappropriate regimens are prescribed.</p> <p>2-8.b. Review PBM reports and pharmacy audit tools to monitor inappropriate ART regimens or components.</p> <p>2-8.c. Utilize PBM reports and pharmacy audit tools to provide training and assistance to ACP Network regarding inappropriate ART regimens or components.</p> <p>2-8.d. Require ADAP contract pharmacies to maintain a separate ADAP medication error log.</p> <p>2-8.e. Provide access to current updates of HIV and related</p>	<p>Gay Campbell</p>	<p>Gay Campbell</p> <p>Dr. Felzien</p>	<p>2-8.a. As needed</p> <p>2-8.b. As needed</p> <p>2-8.c. As indicated during audits</p> <p>2-8.d. As indicated during audits</p> <p>2-8.e. As needed</p> <p>2-8.f. As needed</p>	

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

Objectives	Strategies	Lead	Staff Resources	Timeline	Progress Notes
<p>3-1 Monitor viral load suppression among Ryan White Part B HICP program participants and maintain viral load suppression at 80% or greater.</p>	<p>3-1.a. Create quarterly report from the CAREWare database</p> <p>3-1.b. Utilize the reports to communicate with the district and enrollment staff</p> <p>3-1.c. Review HICP clients who adhere to at least 2 visits for routine HIV medical care in 12 months</p> <p>3-1.d. Share finding with GA ADAP/HICP CQM Workgroup</p>	<p>Satin Francis</p>	<p>Satin Francis</p> <p>Alysia Johnson</p> <p>Data CAREWare Team</p>	<p>3-1.a. Quarterly</p> <p>3-1.b. Quarterly</p> <p>3-1.c. Quarterly</p> <p>3-1.d. Quarterly</p>	
<p>3-2 Monitor client recertifications by due date to prevent delays in payments for health insurance premiums.</p>	<p>3-2.a. Generate monthly reports to monitor this objective.</p> <p>3-2.b. Utilize reports to communicate with district and agency staff regarding clients' recertification status.</p> <p>3-2.c. Provide technical assistance on HICP applications and backup documentation to staff and agencies as needed.</p> <p>3-2.d. Encourage adherence to the Georgia Ryan White Part B/ADAP/HICP Policies and Procedures by the ADAP/HICP enrollment sites.</p>	<p>Satin Francis, Alysia Johnson, and CAREWare Data Team</p>	<p>HICP Team</p> <p>District Liaisons</p> <p>CQM Team</p>	<p>3-2.a. Monthly</p> <p>3-2.b. Monthly</p> <p>3-2.c. As needed</p> <p>3-2.d. During internal reviews as needed</p> <p>3-2.e. As needed</p>	

	<p>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.</p> <p>3-2.f. Provide or coordinate HICP related training for ADAP/ HICP Enrollment Site Coordinators and case managers.</p> <p>3-2.g. Communicate GA HICP updates via conference calls, email listserv, and HIV Office web pages.</p> <p>3-2.h. Convene the Georgia ADAP/ HICP Quality Management Workgroup as needed.</p>			<p>3-2.f. As needed</p> <p>3-2.g. Monthly</p> <p>3-2.h. As needed</p>	
<p>3-3 Monitor completeness of HICP applications submitted.</p>	<p>3-3.a. Generate monthly reports to monitor this objective and share quarterly with the ADAP/HICP Workgroup</p> <p>3-3.b. Utilize the reports to communicate with the district and enrollment staff</p> <p>3-3.c. Provide technical assistance on HICP applications and backup documentation to staff and/or agency as needed</p>	<p>Satin Francis, Alysia Johnson and CAREWare Data Team</p>	<p>HICP Team</p> <p>District Liaisons</p> <p>CQM Team</p>	<p>3-3.a. Monthly</p> <p>3-3.b. Quarterly</p> <p>3-3.c. As needed</p> <p>3-3.d. Daily</p> <p>3-3.e. As needed</p>	

	<p>3-3.d. Ensure that HICP coordinators and case managers comply with the approved Georgia Ryan White Part B/ADAP/HICP Policies and Procedures</p> <p>3-3.e. Provide or coordinate HICP related training for ADAP/HICP enrollment site coordinators and case managers as needed.</p>				
<p>3-4 Conduct an annual audit of HICP client applications and/or recertification forms quarterly.</p>	<p>3-4.a. Review complete audit of all active client files.</p> <p>3-4.b. Utilize the “HICP Documentation Checklist” to evaluate if HICP applications or recertification forms were correctly completed and if approved or denied according to HICP policies and procedures.</p> <p>3-4.c. For application forms that were incomplete, request and obtain required documentation.</p> <p>3-4.d. Create quarterly report card from CAREWare summarizing key findings.</p> <p>3-4.e. Share findings with the ADAP/HICP CQM subcommittee</p>	<p>Satin Francis and Alysia Johnson</p>	<p>HICP Team</p> <p>CQM Team</p>	<p>3-4.a. Annually</p> <p>3-4.b. Daily</p> <p>3-4.c. As indicated</p> <p>3-4.d. Quarterly</p> <p>3-4.e. Quarterly</p>	

	Workgroup to initiate CQI projects as indicated.				
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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 sub-recipients.	<p>4-1.a. Include HAB measures in monitoring tools, chart reviews, and CQM plans.</p> <p>4-1.b. Generate quarterly reports from CAREWare on the HAB PMs and share with HIV Coordinators.</p> <p>4-1.c. Provide technical assistance to improve the accuracy of CAREWare HAB Measure data and reports.</p> <p>4-1.d. Conduct clinical and CM chart reviews.</p>	<p>Sandra Metcalf, Takiyah Turks</p> <p>CAREWare Data Team</p>	<p>CQM Core Team</p> <p>District Liaisons</p>	<p>4-1.a. As needed</p> <p>4-1.b. Quarterly</p> <p>4-1.c. As needed</p> <p>4-1.d. Annually</p>	

<p>4-2 Design CQI project to analyze contributing factors related to decreased rate for Medical Visit Frequency and/or increased rate for Gap in Medical Visits.</p>	<p>4-2.a. Use CQI methodologies to analyze contributing factors related to decreased rate for Medical Visit Frequency and/or increased rate for Gap in Medical Visits.</p> <p>4-2.b. Track statewide data for decreased rate for Medical Visit Frequency and/or increased rate for Gap in Medical Visits via the quarterly HAB Report</p> <p>4-2.c. Consult with sub-recipients and CAREWare Operations Analyst to increase knowledge of data entry processes.</p> <p>4-2.d. Collect data via quarterly reports on missed appointment follow-up.</p> <p>4-2.e. Share best practices with sub-recipients.</p> <p>4-2.f. Assist sub-recipients to develop CQI projects to improve on measures for Medical Visit Frequency and Gap in Medical Visits.</p>	<p>Sandra Metcalf, Takiyah Turks</p>	<p>CQM Core Team</p> <p>Care Team</p> <p>HRSA/HAB</p> <p>Center for Quality Improvement and Innovation</p>	<p>4-2.a. Ongoing</p> <p>4-2.b. Ongoing</p> <p>4-2.c. Ongoing</p> <p>4-2.d. Quarterly</p> <p>4-2.e. As needed</p> <p>4-2.f. As needed</p>	
<p>4-3 Continually monitor the Acuity Scale and Self-Management Model.</p>	<p>4-3.a. Conduct CM Chart Reviews</p> <p>4-3.b. Provide technical assistance to sub-recipients utilizing an acuity scale and self-management model.</p>	<p>QM Coordinator and CM Subcommittee</p>	<p>CQM Core Team</p>	<p>4-3.a. Annually</p> <p>4-3.b. As needed</p>	

<p>4-4 Implement the <i>Georgia HIV/AIDS Case Management Standards</i>.</p>	<p>4-4.a. Distribute revised CM Standards document to the HIV Coordinator in each funded agency via email.</p> <p>4-4.b. Provide technical assistance to sub-recipients to assist with implementation of the CM Standards.</p>	<p>QM Coordinator and CM Subcommittee</p>	<p>CQM Core Team</p>	<p>4-4.a. Annually</p> <p>4-4.b. As needed</p>	
<p>4-5 Coordinate quality-related activities across Ryan White Programs (Parts A, B, C, and D) in Georgia.</p>	<p>4-5.a. Attend the Part A Planning Council and CQM Committee.</p> <p>4-5.b. Include across Ryan White Programs representation on the Part B CQM Core Team.</p> <p>4-5.c. Provide quality-related training to RW staff statewide based on identified needs.</p> <p>4-5.d. Coordinate quality training efforts with GA AETC.</p> <p>4-5.e. Participate in Integrated Planning efforts.</p>	<p>Sandra Metcalf, Takiyah Turks</p>	<p>Part A QM Committee</p> <p>Part B CQM Core Team</p> <p>GA AETC</p>	<p>4-5.a. Monthly</p> <p>4-5.b. Quarterly</p> <p>4-5.c. As needed</p> <p>4-5.d. As needed</p> <p>4-5.e. As needed</p>	
<p>4-6 The percent of pregnant women living with HIV prescribed antiretroviral therapy</p>	<p>4-6.a. As part of the RW Part B Program clinical chart review, assess management of pregnant women living with HIV.</p>	<p>Dr. Felzien, Sandra Metcalf, Takiyah Turks</p>	<p>CQM Core Team</p>	<p>4-6.a. Ongoing</p>	

will be 95% or greater.					
4-7 Monitor, assess and improve perinatal systems of care for women living with HIV and their infants.	<p>4-7.a. Develop a Perinatal Working Group to meet and identify socioeconomic issues that affect pregnant women living with HIV and develop recommendations for systemic improvement.</p> <p>4-7.b. Collaborate with each Care Management Organization (CMO) to strengthen the enrollment of case management for members that are living with HIV, pregnant, and demonstrate need for service.</p> <p>4-7.c. Reinforce the usage of the Clinician Consultation Center “warm line” to assist providers with questions and concerns regarding Perinatal HIV care.</p> <p>4-7.d. Train providers in rural areas on Perinatal HIV care, so patients will not have to travel to Metro Atlanta for care.</p>	Rhonda Harris	<p>Rhonda Harris</p> <p>Perinatal Working Group</p> <p>CQM Core Team</p>	<p>4-7.a. Ongoing</p> <p>4-7.b. Ongoing</p> <p>4-7.c. Ongoing</p> <p>4-7.d. Ongoing</p>	
4-8 Design and implement a statewide CQI Project with the aim to increase Consumer	<p>4-8.a. Use CQI methodologies as needed.</p> <p>4-8.b. Encourage consumer involvement/input during CQM Core Team meetings and include consumer</p>	Sandra Metcalf, Takiyah Turks	<p>CQM Core Team</p> <p>Care Team</p>	<p>4-8.a. Ongoing</p> <p>4-8.b. Quarterly</p> <p>4-8.c. Ongoing</p>	

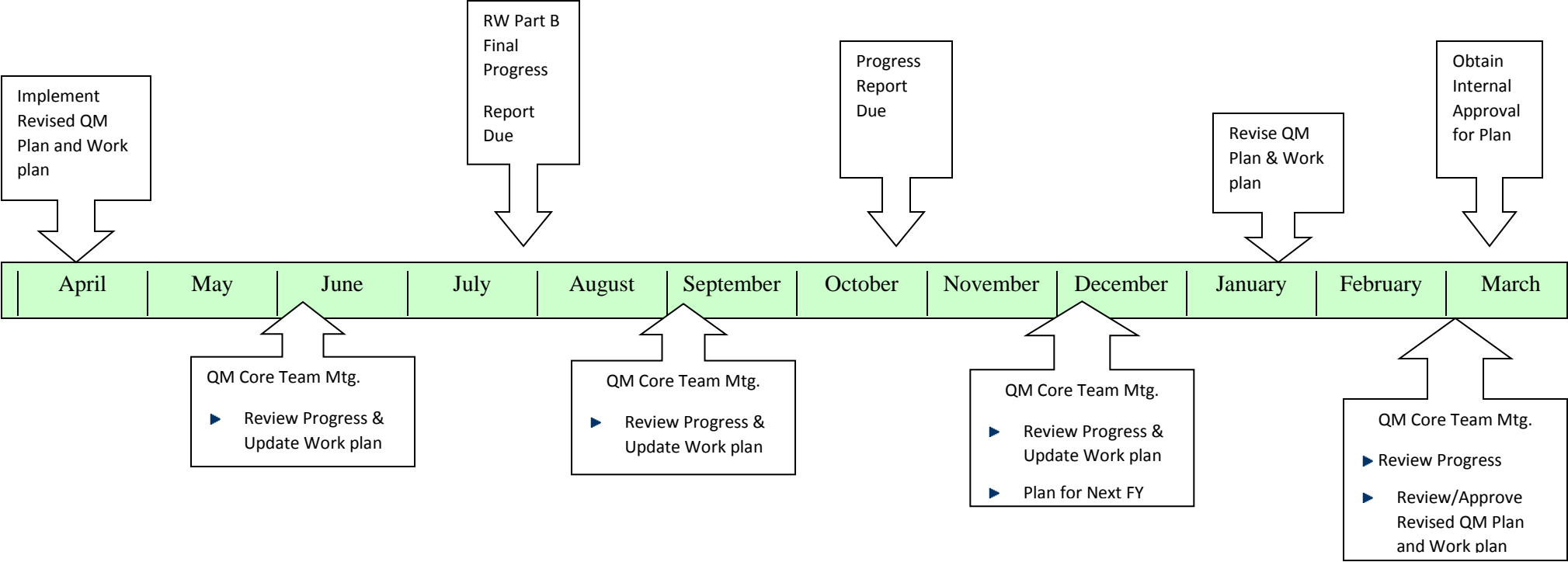
<p>involvement in sub-recipients and state level CQM Committees.</p>	<p>updates as standing agenda item in quarterly CQM Core Team meetings.</p> <p>4-8.c. Engage sub-recipients to report on consumer involvement and assist with recruiting initiatives.</p> <p>4-8.d. Report on project at quarterly CQM Core Team meetings.</p>		<p>HRSA/HAB</p> <p>Center for Quality Improvement and Innovation</p>	<p>4-8.d. Quarterly</p>	
<p>4-9 Monitor measures to verify compliance with HRSA regulations related to the “vigorous pursuit” and payer of last resort.</p>	<p>4-9.a. Communicate updates as they are received.</p> <p>4-9.b. Provide technical assistance based on identified needs, including tools to assist sub-recipients with compliance.</p>	<p>Mirelys Ramos, Rolanda Hall, DeWan Green, Eric Wade, and Shandrecka Murphy</p>	<p>HIV Care Team</p>	<p>4-9.a. As needed</p> <p>4-9.b. As needed</p>	
<p>4-10 Monitor compliance with RW Part B Program, Emerging Communities (EC) and MAI program requirements.</p>	<p>4-10.a. Conduct site visits and provide summary reports, including feedback as appropriate.</p> <p>4-10.b. Update site visit tools for sub-recipients and contractors in accordance with federal program requirements.</p>	<p>Mirelys Ramos, Rolanda Hall, DeWan Green, Eric Wade, and Shandrecka Murphy</p>	<p>Sandra Metcalf and Takiyah Turks</p>	<p>4-10.a. Ongoing</p> <p>4-10.b. Annually</p> <p>4-10.c. Quarterly and as needed</p>	

	<p>4-10.c. Assess services provided at the district level and share common findings with the CQM Core Team.</p> <p>4-10.d. Provide technical assistance to sub-recipients in need of compliance support.</p> <p>4-10.e. Develop processes to improve compliance with RW Part B Program, EC, and MAI program requirements for applicable sub-recipients.</p>			<p>4-10.d. As needed</p> <p>4-10.e. As needed</p>	
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Appendix B
Annual CQM Plan Timeline

Annual CQM Plan Timeline





Appendix C
2019-2020 Ryan White Part B Program
Clinical Quality Management Committees

**Ryan White Part B CQM Program
2019-2020 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
- ❖ Ann Phosai, Administrative Assistant 2
- ❖ Cathy Graves, RN, County Nurse Manager
- ❖ Brandon Dykes, HIV Program Manager
- ❖ Damon Johnson Jr., Program Manager
- ❖ Deborah “Deb” Bauer, MPH, Ryan White (Part D)
- ❖ Derani Jackson, Consumer
- ❖ 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
- ❖ Jared Brumeloe, MPH, Ryan White Database Manager
- ❖ Jeffery Vollman, MPA, District HIV Director
- ❖ Jocelyn McKenzie, MPH, Quality Management Program (Part A)
- ❖ 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
- ❖ Rebecca Moges-Banks, MPH, Ryan White Program Coordinator
- ❖ Rhonda Harris, MPH, MS, Perinatal Coordinator
- ❖ Robin Grant, RN, MSN, Wellness Program Quality Manager
- ❖ Roderick Newkirk, Database Analyst II
- ❖ Rolanda Hall, MPH, District Liaison
- ❖ Rosemary Donnelly, MSN, ANP-BC, ACRN, Director of Clinical Care
- ❖ 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
- ❖ Susan Alt, BSN, ACRN, District HIV Director
- ❖ Suzette Thedford, MPH, Quality Program Analyst
- ❖ Takiyah Turks, MPH, BSN, RN
- ❖ Teresa Hritz, RN Infectious Disease Coordinator
- ❖ Torrance Walden, Peer Support Advocate
- ❖ Vivian Momah, MPH HIV Prevention & Care Planning Group Coordinator

Ryan White Part B CQM Program
2019-2020 Case Management Sub-Committee

- ❖ Adolphus “Tony” Major, Lead Consumer Advocate/ Program Assistant
- ❖ 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 Manager
- ❖ 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
- ❖ 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
- ❖ Torrance Walden, Peer Support Advocate

Ryan White Part B CQM Program
2019-2020 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
- ❖ Jared Brumeloe, MPH, Ryan White Database 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)	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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

<p>AIDS Drug Assistance Program (ADAP)</p>	<ul style="list-style-type: none">• 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.
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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.	Documentation indicating that clients are screened at intake and recertified every 6 months.	Client record review
	Eligible clients referred for enrollment into Private Insurance, Medicare, or Medicaid	Documentation that clients are referred for enrollment into Private Insurance, Medicare or Medicaid.	

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>Eligibility documented for all clients receiving Ryan White Part B Program services:</p> <ul style="list-style-type: none"> - HIV status - Income - Proof of residency - Other healthcare coverage 	<p>Documented HIV+ status.</p> <p>Clients with documentation of financial screening initially then every 6 months; and income at or below 400% of FPL.</p> <p>Documentation of GA residency.</p> <p>Documentation of “vigorous pursuit” and other coverage including Private Insurance, Medicare, or Medicaid.</p>	<p>Documentation of HIV test result or physician signed statement of HIV infection.</p> <p>Documentation of financial screening, proof of residency, and healthcare coverage status at intake and every 6 months.</p>	<p>Client record review</p>
<p>Ryan White-funded providers coordinate the delivery of services and funding mechanisms with other programs or providers.</p>	<p>Memoranda of agreements (MOA) exist with community partners.</p> <p>Contracts executed for subcontracted services.</p> <p>Sub-recipients conducted site visits where subcontracted services are provided.</p>	<p>MOA on file.</p> <p>Contracts on file.</p> <p>Documentation of site visits to subcontractors and evaluation of the quality of services provided by subcontractors.</p>	<p>Review of MOAs and contracts.</p> <p>Site visit reports for subcontractors.</p> <p>Evaluation of the quality of services, such as performance measure reports and client satisfaction surveys.</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
Client security and confidentiality maintained.	<p>Employees' signed confidentiality agreements.</p> <p>Charts secured under lock.</p> <p>Electronic records are password protected.</p> <p>Access to areas with medical records and computers restricted.</p>	<p>Signed confidentiality agreements.</p> <p>Locked storage area for client charts and other information.</p> <p>Computers password protected and secure while in use.</p> <p>Layout of clinic prevents unauthorized access to records and computers.</p>	<p>Review of employee files.</p> <p>Observation of security/ confidentiality measures.</p> <p>Review of written policy and procedures regarding security and confidentiality.</p>
<p>Ryan White funded providers ensure that every client is informed about:</p> <ul style="list-style-type: none"> - 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 Part B Program 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.
Ryan White-funded providers implement CQM Plans with continuous quality	Percent of Ryan White Part B-funded programs with written quality management plans and a current	Written Quality Management Plan.	Review of quality management plans and reports.

Criteria	Indicators	Data Elements	Data Sources & Methods
improvement (CQI) projects.	report of CQI activities and results.	Copies of the most current report of CQI activities and results.	
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.	<p>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.</p> <p>D: # of newly enrolled or reactivated case managed client during the measurement year.</p>	Client Chart Review

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>Ensure that the Acuity Scale is updated every 3-6 months in accordance with the Activities by Acuity Level Document.</p>	<p>Percent of charts that have an Acuity Scale updated every 3-6 months in accordance with the Activities by Acuity Level Document during the measurement period.</p>	<p>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.</p> <p>D: # of case management charts that had an updated Acuity Scale during the measurement year.</p>	<p>Client Chart Review</p>
<p>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.</p>	<p>Percent of case management client charts with documented evidence of periodic re-evaluation and adaptation of the ISP at least every 3-6 months.</p>	<p>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.</p> <p>D: # of case managed clients in a measurement year.</p>	<p>Client chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
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.	<p>N: # of client charts with documented evidence of ongoing monitoring to assess the efficacy of the ISP during the measurement year.</p> <p>D: # of medically case managed clients in a measurement year.</p>	Client chart review
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.	<p>N: # of MCM client charts (acuity level 3-4) with documentation including coordination and follow-up of medical treatment.</p> <p>D: # of MCM clients in a measurement year.</p>	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) charts with a documented treatment adherence visit 2 or more times at least 4 months apart.	<p>N: # of MCM clients (acuity level 3-4) with a documented treatment adherence visit 2 or more times at least 4 months apart in a measurement year.</p> <p>D: # of MCM clients in the measurement year.</p>	Client chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>All MCM clients (acuity level 3-4) who did not have a medical visit in the last 6 months as documented by case manager.</p> <p>(Gap in HIV medical visit)</p>	<p>Percent of MCM client (acuity level 3-4) charts which did not have a medical visit in the last 6 months.</p>	<p>N: # of MCM client (acuity level 3-4) charts that did not have a medical visit in the last 6 months during the measurement year.</p> <p>D: # of case managed clients in a measurement year.</p>	<p>Client chart review</p>
<p>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.</p> <p>(MCM Medical: Visit Frequency)</p>	<p>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.</p>	<p>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.</p> <p>D: # of MCM clients in a measurement year.</p>	<p>Client chart review</p>
<p>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.</p>	<p>Percent of client chart documentation must reflect assistance with linkage to other programs for which clients are eligible.</p>	<p>N: # of client charts with documentation reflecting assistance with linkage to other programs for which clients are eligible during the measurement year.</p> <p>D: # of case managed clients in a measurement year.</p>	<p>Client chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
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) with documented evidence of ongoing assessment of client and other key family members' needs and personal support system, as needed.	<p>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.</p> <p>D: # of case managed clients in the measurement year.</p>	Client chart review
Documentation should reflect that client specific advocacy has occurred during service provision (all levels of acuity).	Percent of client charts with documented evidence of client advocacy (e.g., promotion of client needs for: transportation, housing or/and scheduling of appointments) has occurred during service provision.	<p>N: # of client charts with 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.</p> <p>D: # of case managed clients in the measurement year.</p>	Client chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>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.</p>	<p>Percent of client’s charts with documented that benefits/entitlement counseling and referral services were provided.</p>	<p>N: # of client charts with documented evidence that benefits/entitlement counseling and referral services were provided in the measurement year.</p> <p>D: # of case managed clients in the measurement year.</p>	<p>Client chart review</p>
<p>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.</p>	<p>Percent of case managed client charts with documented housing referrals include: housing assessment, search, placement, advocacy, and financial assistance received.</p>	<p>N: # of case managed client charts with documented housing referrals include: housing assessment, search, placement, advocacy, and financial assistance received in the measurement year.</p> <p>D: # of case managed clients in the measurement year.</p>	<p>Client chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>Case managed client documentation (all levels of acuity) must reflect that clients received assistance in obtaining stable long-term housing as needed.</p>	<p>Percent of case managed client charts with documentation reflecting that clients received assistance in obtaining stable long-term housing.</p>	<p>N: # of case management clients chart with documentation reflecting that clients received assistance in obtaining stable long-term housing in the measurement year.</p> <p>D: # of case managed clients in the measurement year.</p>	<p>Client chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>All Case management chart documentation of services and encounters must include:</p> <ul style="list-style-type: none"> - 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 	<p>Percent of client charts with documented services and encounters.</p>	<p>N: # client charts with documented services and encounters.</p> <p>D: # of case management clients in the measurement year.</p>	<p>Client chart review</p>
<p>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.</p>	<p>Percent of case notes documentation that reflect APIE or SOAP format was utilized in accordance with the GA Case Management Standards.</p>	<p>N: # of charts that utilized APIE or SOAP format case note documentation.</p> <p>D: # of client charts in the measurement year.</p>	

Criteria	Indicators	Data Elements	Data Sources & Methods
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
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			
<p>All ADAP clients must recertify for ADAP every 6 months.</p> <p>Note: Verifying Medicaid status is part of ADAP policy.</p>	<p>ADAP enrollment sites have systems to track ADAP client recertification due dates.</p> <p>Percent of eligible ADAP applicants who successfully recertified according to their recertification due date.</p>	<p>System to track ADAP recertification.</p> <p>N: # of ADAP clients who are reviewed for continued ADAP eligibility in the measurement period.</p> <p>D: # of ADAP clients in the measurement period.</p>	<p>Review of ADAP recertification tracking systems.</p> <p>Client record review</p> <p>Custom report from CAREWare.</p> <p>Georgia Health Partnership Portal to verify Medicaid eligibility.</p>
<p>Local ADAP enrollment site representatives will submit correctly completed ADAP applications to the State ADAP Office.</p>	<p>Percent of correctly completed ADAP applications submitted to ADAP Office during the reporting period.</p>	<p>N: # of correctly completed ADAP applications submitted to ADAP during the reporting period.</p> <p>D: # of ADAP applications submitted to ADAP during the reporting period.</p>	<p>Custom reports from CAREWare.</p>
<p>Initial ADAP applications should be correctly and completely submitted.</p>	<p>Percent of ADAP applications sent back for specified deficiencies.</p>	<p>N: # of ADAP applications sent back to ADAP enrollment sites for a specified deficiency.</p> <p>D: # of ADAP applications submitted to State ADAP Office during the reporting period.</p>	<p>Custom reports from CAREWare.</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>State ADAP Office will approve or deny clients for ADAP services within 2 weeks of receiving a complete ADAP application.</p>	<p>Percent of new ADAP applications approved or denied for ADAP enrollment within 2 weeks of ADAP receiving a complete application during the reporting period.</p>	<p>N: # of applications that were approved or denied within 2 weeks of ADAP receiving a complete application during the reporting period.</p> <p>D: # of complete applications received during the reporting period.</p>	<p>Custom reports from CAREWare.</p>
<p>Local ADAP enrollment site representatives must inform the State ADAP Office when a client discontinues or terminates ADAP services.</p> <p>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.</p>	<p>Local ADAP enrollment sites follow the ADAP “Procedures for Discontinuation.”</p> <p>ADAP Discontinuation Forms are completed and sent to ADAP.</p>	<p>Procedures for discontinuation.</p> <p>Discontinuation Forms</p>	<p>Review of procedures during site visits.</p> <p>Client chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>ADAP clients will receive appropriate antiretroviral (ARV) regimens.</p>	<p>Percent of identified inappropriate ARV regimen or component prescriptions that are reviewed and resolved by ADAP during the measurement year.</p>	<p>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.</p> <p>D: # of inappropriate ARV regimen or components that are prescribed and funded by ADAP.</p>	<p>PBM reports – in process.</p> <p>ACP Network On-Site Audits.</p>
<p>ADAP will conduct an internal audit of new client applications quarterly to determine if the applications and recertifications are completed and approved or denied according to ADAP policies and procedures.</p>	<p>Percent of ADAP new client application forms that were correctly completed during the quarter.</p>	<p>N: # of ADAP new client applications that were correctly completed during the reporting period.</p> <p>D: # of ADAP new client applications reviewed during the reporting period.</p>	<p>Internal audit of ADAP new client applications.</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
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.	<p>N: # of HIV-infected clients in the denominator who received HIV risk counseling as part of their medical care.</p> <p>D: # of HIV-infected clients who had at least one medical visit¹ in the measurement year.</p>	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.	<p>N: # of HIV-infected clients in the denominator who were screened for substance use within the measurement year.</p> <p>D: # of HIV-infected clients who were new during the measurement year, and had a medical visit¹ at least once in the measurement year.</p>	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>HIV-infected clients will receive mental health screening when they initiate primary care.</p>	<p>Percent of new clients with HIV infection who have had a mental health screening.</p>	<p>N: # of HIV-infected clients in the denominator who received a mental health screening.</p> <p>D: # of HIV-infected clients who were new during the measurement year, and had a medical visit¹ at least once in the measurement year.</p>	<p>CAREWare</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
Clinical Performance Measures – Dental Exams			
<p>HIV-infected clients will receive an oral examination by a dentist at least annually.</p>	<p>1) Percent of HIV-infected clients who received an oral examination by a dentist at least once in the measurement year.</p> <p>2) Percent⁶ of HIV-infected clients who received an oral examination by a dentist or dental hygienist at least once in the measurement year.</p>	<p>1) N: # of HIV-infected clients in the denominator who had an oral exam by a dentist in the measurement year².</p> <p>D: # of HIV-infected clients who had at least one medical visit¹ at once during the measurement year.</p> <p>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</p> <p>D: # of HIV-infected clients who had at least one medical visit⁵ with a provider with prescribing privileges during the measurement year.</p>	<p>CAREWare</p> <p>Clinical chart review</p>
Clinical Performance Measures – Medical Visits			
<p>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.</p>	<p>Percent⁶ 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.</p>	<p>1) N: # of clients in the denominator who did not have a medical visit in the last 6-months of the measurement year.</p> <p>D: # of clients, regardless of age, with a diagnosis</p>	<p>CAREWare</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
		<p>of HIV who had at least one medical visit¹ in the first 6-months of the measurement year, excluding clients who died at any time during the measurement year.</p> <p>2) N: # of clients in the denominator who did not have a medical visit in the last 6-months of the measurement year.</p> <p>D: # of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit⁵ 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.</p>	<p>Clinical chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
		<p>6- month period.</p> <p>D: # of clients, regardless of age, with a diagnosis of HIV with at least one medical visit⁵ in the first 6- months of the 24- month measurement period, 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.</p>	
Clinical Performance Measure – HIV Viral Loads			
<p>HIV-infected clients should have viral load repeated every 3-4 months or as clinically indicated to confirm continuous viral suppression.</p> <p>Clinicians may extend the interval to 6 months for adherent, stable clients whose viral load has been suppressed for more than 2 years.</p>	<p>Percent⁶ 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.</p>	<p>N: # of clients in the denominator with a viral load test performed every 6 months.</p> <p>D: # of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit⁵ 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.</p>	<p>Clinical chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>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.</p>	<p>Percent⁶ 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.</p>	<p>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.</p> <p>D: # of clients, regardless of age, with a diagnosis of HIV with at least one medical visit¹⁻⁵ in the measurement year.</p>	<p>CAREWare Clinical chart review</p>
<p>Clinical Performance Measures – Antiretroviral Therapy</p>			
<p>Resistance testing before the initiation or re-initiation of ART.</p>	<p>Percent⁶ of new clients (first visit within the review year) who had resistance testing performed before the initiation or re-initiation of ART.</p>	<p>N: # of clients in the denominator on whom resistance testing was performed before the initiation or re-initiation of ART.</p> <p>D: Number of new clients with a diagnosis of HIV with at least one medical visit⁵ in the measurement year and prescribed ART.</p>	<p>Clinical chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>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.</p>	<p>Percent⁶ of clients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year.</p>	<p>N: # of clients in the denominator prescribed HIV antiretroviral therapy during the measurement year.</p> <p>D: # of clients, regardless of age, with a diagnosis of HIV with at least one medical visit¹⁻⁵ in the measurement year.</p>	<p>CAREWare</p> <p>Clinical chart review</p>
<p>HIV-infected clients will receive appropriate antiretroviral (ARV) regimens, based on current DHHS guidelines.</p>	<p>Percent⁶ of HIV-infected clients on ARV according to Department of Health and Human Services (DHHS) antiretroviral treatment guidelines in the measurement year.</p>	<p>N: # of clients in the denominator on ARV according to DHHS guidelines in the measurement year.</p> <p>D: # of HIV-infected clients on ARV and who had at least one medical visit⁵ in the measurement year.</p>	<p>Clinical chart review</p>
<p>All HIV-infected pregnant females should receive ART, to prevent perinatal transmission as early in pregnancy as possible.</p>	<p>Percent⁶ of HIV-infected pregnant females who were prescribed ART.</p>	<p>N: # of HIV-infected pregnant female clients in the denominator who were prescribed ART.</p> <p>D: # of HIV-infected pregnant female clients who had at least one medical visit¹⁻⁵ during the measurement year.</p>	<p>CAREWare</p> <p>Clinical chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>HIV-infected clients will have fasting lipids evaluated at least annually.</p>	<p>1) Percent of HIV-infected clients, regardless of age, on ART who had a fasting lipid panel in the measurement year.</p> <p>2) Percent⁶ of HIV-infected clients, regardless of age, who had a fasting lipid panel in the measurement year.</p>	<p>1) N: # of clients in the denominator who had a fasting lipid panel in the measurement year.</p> <p>D: # of HIV-infected clients, regardless of age on ART who had at least one medical visit¹ during the measurement year.</p> <p>2) N: # of clients in the denominator who had a fasting lipid panel in the measurement year.</p> <p>D: # of HIV-infected clients, regardless of age, who had at least one medical visit⁵ during the measurement year.</p>	<p>CAREWare</p> <p>Clinical chart review</p>
<p>Clinical Performance Measures – Pap Smears and Sexually Transmitted Infection (STI) Screening</p>			

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>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.</p>	<p>1) Percent of HIV-infected female clients who were screened for cervical cancer in the last three years.</p> <p>2) Percent⁶ of HIV-infected female clients who received a Pap smear per DHHS guidelines.</p>	<p>1) N: # of HIV-infected female clients in the denominator who were screened for cervical cancer in the last three years.</p> <p>D: # of HIV-infected female clients 21 years or older in the measurement year and who had at least one medical visit¹. (excludes client with hysterectomy for non-dysplasia/non-malignant indications).</p> <p>2) N: # of HIV-infected female clients in the denominator who had Pap smear documentation, per DHHS guidelines, in the measurement year.</p> <p>D: # of HIV-infected female clients 18 years or older <u>or</u> who reported sexual activity and had at least one medical visit⁵ during the measurement year. (excludes women with hysterectomy for benign reason).</p>	<p>CAREWare</p> <p>Clinical chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>All female clients with abnormal Pap smear results will have documentation for diagnostic evaluation.</p>	<p>Percent⁶ 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.).</p>	<p>N: # of HIV-infected female clients in the denominator with abnormal Pap smear results having documentation for diagnostic evaluation.</p> <p>D: # of HIV-infected female clients 18 years or older <u>or</u> who reported sexual activity and had at least one medical visit⁵ during the measurement year. (excludes women with hysterectomy for benign reason) with abnormal Pap smear results.</p>	<p>Clinical chart review</p>
<p>HIV-infected clients at risk for an STI will be screened for chlamydia at least annually.</p>	<p>Percent of clients with HIV infection at risk for STIs who had a test for chlamydia within the measurement year.</p>	<p>N: # of HIV-infected clients in the denominator who had a test for chlamydia.</p> <p>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 visit¹ at least once in the measurement year.</p>	<p>CAREWare</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>HIV-infected clients at risk for an STI will be screened for gonorrhea at least annually.</p>	<p>Percent of clients with HIV infection at risk for STIs who had a test for gonorrhea within the measurement year.</p>	<p>N: # of HIV-infected clients in the denominator who had a test for gonorrhea.</p> <p>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 visit¹ at least once in the measurement year.</p>	<p>CAREWare</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>HIV-infected clients will be screened for syphilis at least annually.</p>	<p>Percent⁶ of HIV-infected clients who were screened for syphilis in the measurement year.</p>	<p>N: # of HIV-infected clients in the denominator who had a serologic test for syphilis performed in the measurement year.</p> <p>D: # of HIV-infected clients who had at least one medical visit¹⁻⁵ in the measurement year.</p>	<p>CAREWare</p> <p>Clinical chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
Clinical Performance Measures – Tuberculosis (TB), and Hepatitis Screening			
<p>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.</p>	<p>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.</p> <p>2) Percent⁶ 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.</p>	<p>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.</p> <p>D: # of HIV-infected clients who had at least two medical visits¹ 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.</p> <p>2) N: # of clients in the denominator who had TB screening test performed and results interpreted at least once since diagnosis of HIV infection.</p> <p>D: # of HIV-infected clients with at least one medical visit⁵ in the measurement year, excluding clients with documentation of a medical reason for not</p>	<p>CAREWare</p> <p>Clinical chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
		performing TB screening test.	
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.	<p>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.</p> <p>D: # of clients, regardless of age, with a diagnosis of HIV and who had at least two medical visits¹ during the measurement year, with at least 60 days in between each visit.</p>	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
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 at least once in the measurement year, excluding clients newly enrolled during the 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	CAREWare
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Criteria	Indicators	Data Elements	Data Sources & Methods
	<p>2) Percent⁶ of clients with HIV infection who completed the vaccination series and antibody assessment for Hepatitis B according to DHHS Guidelines</p>	<p>vaccination series and antibody assessment for Hepatitis B per DHHS Guidelines.</p> <p>D: # of HBV susceptible HIV-infected clients who had a medical visit⁵ 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.</p>	<p>Clinical chart review</p>
<p>All HIV-infected clients without valid contraindications should receive the influenza vaccine annually.</p>	<p>Percent⁶ of clients with HIV infection who have received influenza vaccination within the measurement period.</p>	<p>1) N: # of HIV-infected clients in the denominator who received influenza vaccination or who reported² receipt of influenza vaccination during the current season.</p> <p>D: # of HIV-infected clients who had a visit¹ 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).</p>	<p>CAREWare</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
		<p>2) N: # of HIV-infected clients in the denominator with documentation of receipt of influenza vaccination in the current season.</p> <p>D: # of HIV-infected clients who had a medical visit⁵ 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).</p>	Clinical chart review
All HIV-infected clients without valid contraindications, should receive the pneumococcal vaccine.	Percent of clients with HIV infection who ever received pneumococcal vaccine.	<p>N: # of HIV-infected clients in the denominator who ever received pneumococcal vaccine.</p> <p>D: # of HIV-infected clients who had a medical visit¹ at least once in the measurement year, excluding clients with CD4 counts < 200 cell/mm³ within the measurement year.</p>	CAREWare
Clinical Performance Measures – Opportunistic Infection Prophylaxis			
All HIV-infected clients with CD4	Percent ⁶ of HIV-infected clients who	1) N: # of HIV-infected clients in the denominator	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>counts below 200 cells/mm³ should receive chemo-prophylaxis against <i>Pneumocystis pneumonia</i> (PCP).</p>	<p>were prescribed PCP prophylaxis.</p>	<p>with CD4 counts below 200 cells/mm³ who were prescribed PCP prophylaxis.</p> <p>D: # of HIV-infected clients with CD4 counts below 200 cells/mm³ and who had at least two medical visits¹ 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/mm³ during the three months after a CD4 count below 200 cells/mm³.</p> <p>2) N: # of HIV-infected clients in the denominator with CD4 counts below 200 cells/mm³ or CD4 percent less than 14% who were prescribed PCP prophylaxis.</p> <p>D: # of HIV-infected clients with CD4 counts below 200 cells/mm³ or CD4 percent less than 14% and who had at least one medical visit⁵ during the measurement year, excluding clients who did</p>	<p>Clinical chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
		<p>not receive PCP prophylaxis because there was a CD4 count above 200 cell/mm³ during the three months after a CD4 count below 200 cells/mm³ or documented CD4 count 100-200 cells/mm³ and HIV RNA remain below limit of detection for at least 3-6 months</p>	
<p>All HIV-infected clients with CD4 counts below 50 cells/mm³ should receive chemo-prophylaxis against <i>Mycobacterium avium</i> complex (MAC).</p>	<p>Percent⁶ of HIV-infected clients with CD4 counts below 50 cells/mm³ who were prescribed MAC prophylaxis in the measurement year.</p>	<p>N: # of HIV-infected clients in the denominator with CD4 counts below 50 cells/mm³ who were prescribed MAC prophylaxis.</p> <p>D: # of HIV-infected clients with CD4 counts below 50 cells/mm³ and who had at least one medical visit¹⁻⁵ during the measurement year, excluding clients with disseminated MAC.</p>	<p>CAREWare</p> <p>Clinical chart review</p>

¹CAREWare - Medical visit data is from Outpatient/Ambulatory Medical Care may include primary care, lab, medication pick up, etc.

²CAREWare - client self-report limitations.

⁴Client self-report not accepted.

⁵Chart review - medical visit with a prescribing provider before November 1st of measurement year.

⁶Clinical chart review percent is weighted average.

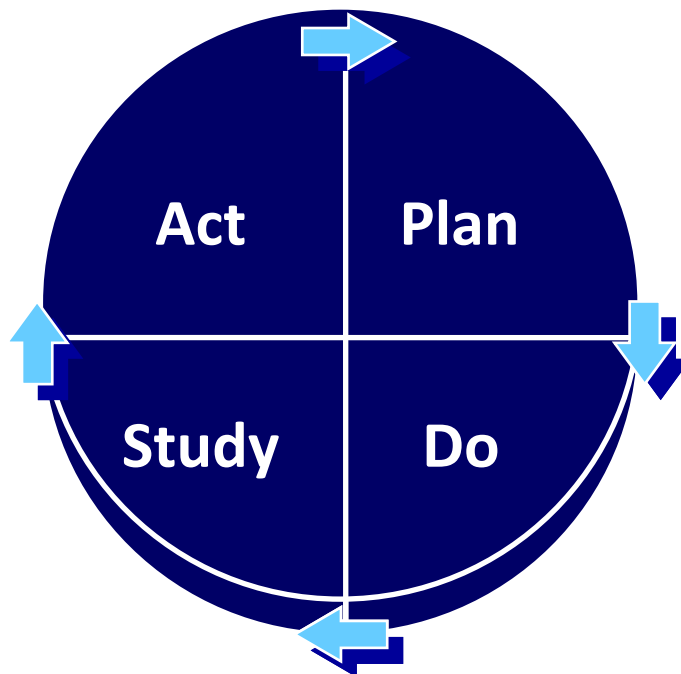


Appendix F
Model for Improvement

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



<p>ACT</p> <ul style="list-style-type: none"> • What changes are to be made? • Next cycle? • Adapt, Adopt, Abandon? 	<p>PLAN</p> <ul style="list-style-type: none"> • Objective • Questions and predictions (why) • Plan to carry out the cycle (who, what, where, when)
<p>STUDY</p> <ul style="list-style-type: none"> • Complete the analysis of the data • Compare data to predictions • Summarize what was learned 	<p>DO (Small Scale)</p> <ul style="list-style-type: none"> • Carry out the plan • Document problems and unexpected observations • Begin analysis of the data

From the HAB/NQC Ryan White Part B Program 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
CQM Plan Approval

FY2019-2020 CQM Plan and Work Plan Approval

The FY2019-2020 RW Part B CQM Plan and Work Plan are approved by the following:

Ryan White Part B COM Core Team

3/29/2019

Date

Marisol Cruz

Marisol Cruz, D.B.A, HIV Care Manager

Georgia Department of Public Health

3/29/2019

Date

William Lyons

William Lyons, HIV Office Director

Georgia Department of Public Health

4-3-19

Date



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