Calendar Year 2025

CLINICAL QUALITY MANAGEMENT PLAN

RYAN WHITE PART A

Date of Approval: March 13, 2025

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Section 1: INTRODUCTION

As a Ryan White Part A (RWPA) Recipient, Clark County's Office of HIV manages a Clinical Quality Management (CQM) program that develops, implements, and oversees an annual CQM plan and quality improvement system. This systemic approach ensures that HIV health services are consistent with the most recent Health and Human Services (HHS) guidelines and clinical practice standards. The CQM program also ensures that service utilization, baseline data, and outcome information is used to monitor progress and trends in the Las Vegas Transitional Grant Area (LVTGA) that consist of three counties -Clark and Nye in Nevada and Mohave in Arizona. This plan is considered a "living" document intended to be modified and updated as part of the RWPA clinical quality improvement process.

Section 2: QUALITY STATEMENT

Our mission is to deliver a proactive, innovative, and customer centered CQM program that ensures high-quality service delivery that drives meaningful improvement in health outcomes. By fostering a culture of excellence, collaboration, and equity, we aim to support People with Lived Experience (PWLE) in achieving optimal health and well-being.

Section 3: ANNUAL QUALITY GOALS

The goal of our 2025 annual CQM program priorities is to enhance health outcomes for PWLE by ensuring care is effective, efficient, equitable, and patient-centered. The purpose of the CQM program is to provide a structured framework for continuously monitoring, evaluating, and improving the quality of care and services through data-driven strategies and collaborative engagement. The final approval of this plan is granted by the Project Director.

Goal 1: Enhance patient care through continuous quality improvement initiatives that address the unique needs of individuals across the TGA, ensuring better health outcomes for all.
Goal 2: Elevate the quality of core medical and support services, promote well-being, and improve measurable health improvements.
Goal 3: Strengthen performance measurement systems to accurately assess patient outcomes and drive targeted improvements.
Goal 4: Empower PWLE, to actively participate in quality improvement process fostering inclusive and patient centered care solutions.

Section 4: QUALITY INFRASTRUCTURE

The 2025 CQM Advisory Committee will consist of a team of multidisciplinary individuals that work together in a synchronized and ongoing manner, to improve **P**atient **C**are, **H**ealth **O**utcomes, and **P**atient **S**atisfaction (PCHOPS). The committee will be responsible for participating in monthly CQM meetings to ensure a structured and collaborative approach that supports our CQM program. The purpose of the CQM Advisory Committee is to have regularly scheduled meetings to foster accountability, streamline decision-making, encourage collaboration, monitor, and evaluate performance, and demonstrate a commitment to continuous quality improvement. A list of roles, responsibilities, and expectations of the CQM Advisory Committee, RWHAP staff, RWHAP consultants, RWHAP subrecipients, RWPA consumers, and stakeholders are defined on the table below.

Clinical Quality Management Advisory Committee		
Representative	**Role**	**Responsibilities**
Part A Ryan White Project Director	Committee Member	• Endorses, champions, and raises the visibility of the CQM program and approves the CQM plan. • Has final accountability of the CQM program. • Provides overarching leadership and support.
Part A Clinical Quality Management Analyst	Committee Chair	• Administers, develops, and implements the CQM program. • Writes annual CQM plan. • Facilitates the CQM Advisory Committee meetings. • Provides capacity building, technical assistance, and support training to subrecipients. • Creates and shares resources (newsletters & video tutorials). • Disseminates programmatic activities and accomplishments. • Communicates systematic updates to the service providers, consumers, Planning Council, and community at large.
Part A Senior Management Analyst	Committee Member	• Collaborates with CQM Committee to ensure the alignment of goals among the Part A, MAI, and EHE programs. • Supports the development of subrecipient CQM goals, Plan, Do, Study, Act (PDSA) cycles and implementation status.
Part A Program Management Analyst	Committee Member	• Provides support in the selection and implementation of Quality Improvement (QI) projects based on trends and needs of the service delivery system.
Part A Compliance Management Analyst	Committee Member	• Provides support directed at policies, procedures, and the compliance component of the CQM program. • Ensures subrecipients meet all regulations and contract requirements.
EHE Coordinator	Committee Member	• Provides support to the CQM program in relation to EHE initiatives.
Collaborative Research	Consultant	• Provides support to the CQM program and committee chair.
Subrecipients	Committee Members	• Actively engaged in capacity building training and retraining in QI PDSA methodology. • Actively participates in Lab Data Days to integrate data insights into their workflows and enhance data-driven decision-making. • Conducts PDSA cycles, presents QIP proposals and outcomes. • Acts as subject matter experts in monthly CQM Advisory Committee meetings. • Leads QI and data-driven conversations with their internal CQM team and is engaged in planning and evaluation. • Routinely reviews performance measures and is accountable for entering current and consistent data for collection and reporting purposes. • Conducts consumer satisfaction surveys to measure the impact of the RWPA Program. • Meets contract deliverables.
TriYoung Staff	Data Contractor/Consultant	• Provides CAREWare & RWISE maintenance, customization, documentation, technical support, and reporting assistance.
Part B (Ad-Hoc)	Clinical Quality Management Analyst	• Collaborates with RWPA Clinical Quality Management Analyst to align and leverage community-wide efforts aimed at improving Patient Care, Healthcare Outcomes, Patient Satisfaction (PCHOPS). • Requests data from State HIV Surveillance, Office of Public Health, and Epidemiology (OPHIE) Program.

Part C	Clinical Quality Management Analyst	• Collaborates with the RWPA Clinical Quality Management Analyst.
Part D (Ad-Hoc)	Ryan White Program Management Analyst Pediatrics	• Shares resources, knowledge, and expertise by providing input on CQM activities.
Stakeholder	**Role / Participation**	
Part A Planning Council	• Periodically updates standards of care. • Reviews and utilizes service data and reports. • Uses quality management data in decision-making	
People with Lived Experience (Ad-Hoc)	• Participate in quarterly CQM Advisory Committee meetings. • Participate in monthly Planning Council meetings. • Participate in satisfaction surveys (online, email, etc.) • Participate in focus groups, market research, and observations.	
HRSA	Establishes guidelines and standards for performance and program compliance	
Pacific AIDS Education and Training Center (PAETC)	AETCs are regional centers providing education and training for primary care professionals and other AIDS-related personnel. AETCs provide targeted, multidisciplinary education and training programs including presentations on updated clinical guidelines, information, on new pharmaceuticals and chronic disease management.	

Section 5: EVALUATION

The CQM Analyst updates and evaluates the effectiveness of the CQM program by collecting and analyzing qualitative data using the Roses, Buds, and Thorns reflective activity by categorizing feedback and insights from the CQM committee and PWLE.

- Roses, represents what is working well, by highlighting the programs successes and strengths such as: improved patient outcomes, streamlined processes, or innovative solutions.
- Buds, represents opportunities for growth, by identifying areas with potential for improvement or expansion such as: untapped resources, emerging data trends, or new initiatives that could be enhanced.
- Thorns, represents challenges and barriers we faced. By discussing challenges, obstacles, or issues, such as data gaps, misaligned priorities, or resource constraints that hindered the programs progress.

Section 6: PERFORMANCE MEASUREMENT

Performance measurement is the systematic collection and analysis of data. A successful program translates into viral suppression. Performance measures are required, at minimum for any Service Category utilized by 15% or more of clients in the LVTGA. Performance measures shall be defined by the COUNTY and are included in contracts for subrecipients funded to provide services that meet this criterion to ensure that we are meeting the minimum required Performance Measures per funded service category as prescribed on page 4 of Policy Clarification Notice (PCN) 15-02.

To appropriately assess outcomes, measurement must occur. Performance measurement indicators let us know how we are doing; they also inform us if we met our goals, if improvements are necessary, whether our consumers are satisfied, and if our process aligns with our plan**.** Since the CAREWare database is "live," SPOCs use CAREWare performance measurement reports to collect and analyze service category performance measurement data, monthly. The LVTGA uses the Service Utilization data report from CAREWare as a baseline to monitor performance measurement improvements. The service category performance measures the LVTGA is currently monitoring are listed on the table below.

Las Vegas Transitional Grant Area 2025 Service Category Performance Measures	
EIS01: EIS Linkage to Care	
Description	Percentage of "newly diagnosed" patients, regardless of age, who attended a routine HIV medical care visit within 1 month of HIV diagnosis.
Numerator	Number of "newly diagnosed" patients, regardless of age who attended a routine HIV medical care visit within 1 month of HIV diagnosis.
Denominator	Number of "newly diagnosed" patients, regardless of age, with an HIV diagnosis in the 12-month measurement year.
oVS-OAHS: HIV Viral Suppression	
Description	Percentage of OAHS patients with HIV whose last viral load in the measurement year is <200 copies.
Numerator	Number of patients with HIV whose last viral load is <200 copies at the last viral load test during the measurement year.
Denominator	Number of patients with HIV with at least one OAHS visit in the measurement year.
oVS- MCM: HIV Viral Suppression	
Description	Percentage of MCM patients with HIV whose last viral load in the measurement year is <200 copies.
Numerator	Number of patients with HIV whose last viral load is <200 copies at the last viral load test during the measurement year.
Denominator	Number of patients with HIV with at least one MCM visit in the measurement year.
RoC: Receipt of Care	
Description	The percentage of persons with diagnosed HIV who had a CD4 or viral load test during the calendar year.
Numerator	Number of persons aged ≥13 years with diagnosed HIV infection who had a care visit during the calendar year, as measured by documented test results for CD4 count or viral load.
Denominator	Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.

CAREWare's Aggregate Data tool is available to SPOCs and their quality improvement teams to support the development and monitoring of their individual QIPs. The Performance Measurement Module is a tool that also helps subrecipients identify health disparities, address priority populations, reengage clients in care and share data with stakeholders. Providers will submit a QIP proposal and will monitor the performance measures that are specific to their QIP.

Section 7: QUALITY IMPROVEMENT

The CQM Analyst works with subrecipients to build capacity and provide guidance on prioritizing measures and data collection to identify opportunities for improvement and monitor QI activities. Technical assistance is provided to SPOCs in the development, implementation, and maintenance of their individual quality improvement projects. QI data is collected, maintained, analyzed, and shared with appropriate stakeholders through outcome reports and presentations. The LVTGA will use the PDSA model for improvement to learn and build knowledge and expertise over time as they develop a change, test a change, or implement a change that will result in improvement.

SPOCs from each agency will propose an agency specific Quality Improvement Project (QIP) by documenting and tracking qualitative and quantitative data that informs if they focused on developing a change, testing a

change, or implementing a change on a Plan, Do, Study, Act (PDSA) form on a biannual basis. The four-step PDSA Model for Improvement process is:

1. **Plan** – Develop an objective with questions and predictions.
2. **Do** – Carry out the plan on a small scale and document the process.
3. **Study/Check** – Analyze the data, compare it to the "plan" section and document process.
4. **Act** – Adapt the new process, abandon it, or revise and begin the cycle again.

The Committee also produces an annual report of the monitored performance measures and compares the data to the LVTGA's benchmark and predicted outcomes. Collectively, committee members share outcomes, surprises, successes, and best practices. If the subrecipient is not satisfied with the result, members from quality improvement teams will iterate through the process and repeat the cycle with different strategies until the desired process or outcome is satisfactory. If the Committee determines the plan resulted in success, members will standardize the improvement and will begin to use it regularly.

An overview of the Quality Improvement activities that the CQM Advisory Committee has identified is in the table below. This is a "living document" and contains the current and future QI activities. This table will be revised regularly. The table lists the activities, action steps, responsible staff, timeframe, and comments/outcome notes section.

Section 8: WORK PLAN

Activity	Action Steps	Responsible Staff	Time Frame	Comments / Outcomes
Goal 1: Enhance patient care through continuous quality improvement initiatives that address the unique needs of individuals across the TGA, ensuring better health outcomes for all.				
Part A Project Director, Senior Management Analyst, CQM Analyst, EHE Management Analyst, Program Analyst, Compliance Analyst, CR Consultant and SPOCs, meet monthly to discuss updates, challenges, successes, and quality improvement.		Office of HIV Staff, CR, & CQM SPOC	Jan. - Dec. 2025	
LVTGA SPOCs submit their Quality Improvement Project (QIP) proposal through the PDSA form and will act as ambassadors as they monitor individualized site based QIPs. **Action Steps**: SPOCs will submit PDSAs twice a year. See the subrecipient timeline for reporting on table to the right and on page 12.		CQM SPOCs	**First Cycle:** QIP proposal due April 10, 2025 QIP Cycle ends August 1, 2025 Reporting of Outcomes are due August 18, 2025. **Second Cycle:** QIP proposal due September 10, 2025 QIP Cycle ends January 1, 2026 Reporting of Outcomes are due February 16, 2026.	
CQM Technical Assistance, Training & Capacity Building				
Capacity Building • Review updated PDSA Form • Review 2024 CQM Program Timeline		CR CQM Analyst CQM SPOCs	March 2025	This information will be delivered at the March CQM Meeting and will be posted on Basecamp.
Capacity Building, Technical Assistance Support Sessions Create and distribute QIP presentation templates for SPOCs to deliver agency QIP proposal and outcome report information.		CQM Analyst & CR	April 2025	CQM Analyst will provide capacity building and support for SPOCs presentations.
Goal 2: Improve the quality of core medical and support services provided by the TGA.				

Identify LVTGA service categories and performance measures that will be monitored.	Create a 2023 Service Utilization Data Report to determine PMs that will be monitored.	Clinical Quality Management Analyst	February 2025	The frequency of these reports will be pulled on a quarterly basis.
Increase the LVTGA percent of **linked to care** EIS clients from 68.80% to 75%. Increase the LVTGA percent of **virologically suppressed** MCM clients from 86.74% to 90%. Increase the LVTGA percent of **virologically suppressed** OAHS clients from 91.71% to 93%. Attain an accurate count of Receipt of Care persons ≥13 years with diagnosed HIV who had at least one CD4 or viral load test during the calendar year. Increase the LVTGA percent of clients retained in care from 80.63% to 85%	The CQM Analyst will run the LVTGA PM data using CAREWare's Performance Measurement Module.	CQM Analyst	May 10, 2025 Aug. 10, 2025 Nov. 10, 2025 Feb. 10, 2026	The frequency of these reports will be pulled on a quarterly basis. Updates shared at the quarterly CQM meetings in June, September, and January.
Activity	**Action Steps**	**Responsible Staff**	**Time Frame**	
SPOCs present data outcomes on a biannual basis.	SPOCs will track and collect data on the PDSA data collection table and will present outcomes to stakeholders.	SPOCs	QIP Reporting of Outcomes due: August 18, 2025, and February 16, 2026	
Goal 3: Strengthen performance measurement systems to accurately assess patient outcomes and drive targeted improvements.				
Lab Data Import Process	Provide a comprehensive overview of how data is captured and reported.	CQM Analyst	March 2025	Communicate with committee that there is a delay in reported data.
Create a schedule with Data Days and Reporting Days	Create a Subrecipient Timeline for Reporting on Miro. Create Timeline for Reporting Data Collection table on the PDSA form. Add Subrecipient Timeline for Reporting on the annual CQM Plan.	CQM Analyst	February 2025	CR will communicate the timeline at the February Quality Quickie.
Create a schedule of Quality Quickie and CQM Dates	CQM Analyst and CR plan on meeting monthly. CQM Analyst sent calendar invitations to CQM Advisory Committee to plan.	CQM Analyst CR	January 2025	Recipient communicated this information via email and calendar invites.
Individual Capacity Building	Meet in person or online with the Clinical Quality Management Analyst to discuss QIP performance measures and PDSA Cycle documentation.	CQM Analyst & Subrecipients	April 10 Sept. 10	Held in person or online. This is an opportunity for the CQM Analyst and the SPOCs to discuss and discover opportunities around quality improvement.
Capacity Building Lab Data Days	Provide capacity building, technical assistance, and support sessions online.	CQM Analyst Subrecipients	April 2025 July 2025 Oct. 2025 Jan.	CQM Analyst will provide morning and afternoon sessions to maximize participation.

			2026	
Goal 4: Empower PWLE, to actively participate in quality improvement process fostering inclusive and patient centered care solutions.				
Invite consumers to the CQM meetings for participation.	Determine and document the mechanisms for inviting clients in CQM activities.	Recipient CR	Ongoing	
English & Spanish content to engage participants. Spanish Community Engagement Video English Community Engagement Video	Create, post, and distribute Community Engagement videos in English and Spanish through providers and on the LVTGA website Learning Portal.	Clinical Quality Management Analyst	Ongoing	The purpose of these videos is to invite and engage community partners and consumers in the CQM decision-making process at the LVTGA CQM Quarterly Meetings.
Activity	**Action Steps**	**Responsible Staff**	**Time Frame**	**Comments / Outcomes**
LVTGA CQM Program Assessment				
Thorns, Roses, & Buds	CQM Committee participates in an analysis of the TGA to share assess the current CQM program.	Part A Project Director, Senior Management Analyst, Management Analysts, and CQM SPOCs	Q3	
Organizational Assessment	CQM Committee will participate in a formal Organizational Assessment.	SPOCs	Q4	

Section 9: CAPACITY BUILDING

Capacity Building, Information Sharing, and Communication

The CQM Analyst shares the CQM work plan, relevant resources, webinars, articles, and success stories with the CQM committee, consumers, and internal stakeholders. Resources include information from the Center for Quality Improvement and Innovation (CQII) center, HRSA/HAB, Target HIV website, Pacific AIDS Education and Training Center Program (PAETC) and other recognized organizations in HIV care. CQM resources may address QI topics or topics emphasizing gaps in care. In addition, the Clinical Quality Management Analyst creates video tutorials to build capacity, engage the community, and provide support to subrecipients. Subrecipients shall set time aside on data days to import, log and report quarterly data. The Clinical Quality Management Analyst also provides frequent capacity building, technical assistance, and support sessions to providers on an as-needed basis including Lab Data Section 9Days on a quarterly basis. Technical assistance, training, and support sessions provided by the Clinical Quality Management Analyst are in person and online. The table below outlines the delivery of communication at the LVTGA.

The Annual Quality Management Plan, CQM agendas and meeting minutes are archived on the LVTGA website and on Basecamp.

QUALITY MANAGEMENT COMMUNICATION			
Information	**Stakeholder**	**Frequency**	**Communication Methodology**
Annual CQM Plan	HRSA Planning Council Subrecipients	Annually	• Formal written document • Posted on LVTGA website
Service Standards	HRSA Planning Council Program Management Analyst (MA) Subrecipients Clients	As needed	• Formal written documents. • Posted on the LVTGA website
Performance Measures Outcome Reports	HRSA Planning Council Subrecipients Clients	Annually	Annual Report
Annual Site Reviews	Planning Council Compliance & Monitoring MA Subrecipients HRSA	Annually	Annual Report
Monthly Service Call & Reports	HRSA Project Officer	Monthly	Narrative report
CQM Newsletters	CQM Committee Subrecipients	Quarterly	Quarterly communication on LVTGA website
Service Category Reporting Days	CQM	Quarterly	CQM Advisory Committee Meetings
Quality Improvement Projects (Cycle 1 & Cycle 2)	SPOCs	Biannually	CQM Advisory Committee Meetings
Capacity Building, Technical Assistance, and Support Sessions	CQM & SPOCs	Ongoing	• In Person • Online
CQM Advisory Committee Meetings Quality Quickies	CQM, SPOCs, Collaborative Research	Monthly	• Online • Basecamp • In Person

Commonly Used Acronyms and Definitions in CQM
CAREWare an electronic health and social support services information system for HRSA's Ryan White HIV/AIDS Program recipients and providers.
Client is used interchangeably with the terms "patient" and "consumer."
Clinical Quality Management (CQM) encompasses infrastructure, measurement, and improvement. It is also used interchangeably with CQI.
Clinical Quality Improvement (CQI) is used interchangeably with CQM.
Center for Quality Improvement and Innovation (CQII) a resource that provides technical assistance on quality improvement to Ryan White HIV/AIDS Program recipients.
Enhanced HIV/AIDS Reporting System (eHARS) - is a browser-based, CDC-developed application that assists health departments with reporting, data management, analysis, and transfer of data to CDC.
Health and Human Services (HHS) is the U.S. Department of Health and Human Services that enhances the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.
Health Resources and Services Administration (HRSA)and the HIV/AIDS Bureau (HAB) is the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) administers the Ryan White Program.
Human Immunodeficiency Virus (HIV) is a virus that attacks cells that help the body fight infection, making a person more vulnerable to other infections and diseases. It is spread by contact with certain bodily fluids of a person with HIV, most commonly during unprotected sex (sex without a condom or HIV medicine to prevent or treat HIV), or through sharing injection drug equipment.
PCHOPS – Patient **C**are, **H**ealth **O**utcomes, **P**atient **S**atisfaction
People With Lived Experience (PWLE) refers to infants, children, adolescents, and adults who have HIV.
Plan, Do, Study, Act (PDSA) Methodology is a four-step process for quality improvement. The first step (plan), develop an objective with questions and predictions, The second step (do), carry out the plan on a small scale and document the process. The third step (study), analyze the data, compare it to the "plan" section and document the process. The fourth step (act), adapt to the new process, abandon it, or revise it and begin the cycle again.
Policy Clarification Notice (PCN) 15-02
Provider – includes the terms "subrecipient", "agency", and "organization"
Qualitative Data describes qualities or characteristics. It is collected using questionnaires, interviews, or observation, and frequently appears in narrative form.
Quantitative Data is defined as the value of data in the form of counts or numbers where each dataset has a unique numerical value associated with it.
Ryan White HIV / AIDS Program (RWHAP)
Subrecipient includes the terms "provider," "agency," and "organization."
Transitional Grant Area (TGA) are population centers that are the most severely affected by the HIV/AIDS epidemic. To be an eligible TGA, an area must have 1,000 to 1,999 reported AIDS cases in the most recent 5 years.
Quality Improvement (QI) is the framework used to systematically improve the ways care is delivered to patients.
Quality Improvement Project (QIP) is a targeted, data-driven effort to enhance processes or systems within an organization, aiming for better efficiency, effectiveness, and satisfaction through a structured, participatory approach.

Subrecipient Timeline for Reporting 2025		
Cycle 1	If the data reporting day falls on a weekend or holiday, the data reporting will be due the first business day after the weekend or holiday. 	**Cycle 2**
QIP Proposal Due April 10, 2025		QIP Proposal Due September 10, 2025
March 1, 2025		August 1, 2025
April 1, 2025		September 1, 2025
May 1, 2025		October 1, 2025
June 1, 2025		November 3, 2025
July 2, 2025		December 1, 2025
August 1, 2025		January 1, 2026
Cycle 1 Outcomes Report Due August 18, 2025		Cycle 2 Outcomes Report Due February 1, 2026

Recipient Clinical Quality Management Analyst Timeline for Reporting 2025
Clinical Quality Management Analyst shares LVTGA Performance Measures to the Planning Council and stakeholders.
March 25, 2025 – Q1 Performance Measurement updates.
June 24, 2025 – Q2 Performance Measurement updates.
September 30, 2025 – Q3 Performance Measurement updates.
January 27, 2025 – Q4 Performance Measurement updates.