Calendar Year 2026

CLINICAL QUALITY MANAGEMENT PLAN

RYAN WHITE PART A

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Approved by: Heather R. Shoop, Project Director

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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 2026 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 2026 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 and performance measures to service providers, consumers, Planning Council, and community at large.
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.
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 represent what is working well, by highlighting the programs successes and strengths such as: improved patient outcomes, streamlined processes, or innovative solutions.
- Buds represent 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 represent challenges and barriers we face. By discussing challenges, obstacles, or issues, such as data gaps, misaligned priorities, or resource constraints that hindered the program's 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 the Annual Clinical Quality Management Plan 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 2026 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.
C5-MCM: Retention in Care	
Description	Percentage patients with HIV who had at least two medical encounters in the measurement year and received a referral for healthcare and support services.
Numerator	Number of patients with HIV who had at least two medical visits at least 90 days apart during the measurement year and received a referral for healthcare support services.
Denominator	Number of patients with HIV who had at least one medical visit during the measurement year.
C5-RHSS: Referral for Healthcare and Support Services Annual Retention in Care	
Description	Percentage of people with diagnosed HIV who had a CD_4 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 CD_4 count or viral load.
Denominator	Number of persons aged ≥13 years with HIV diagnosed by previous year-end and alive at year-end.
C5-OAHS: Retention in Care	
Description	Percentage of patients with HIV who had at least two medical encounters at least 90 days apart during the measurement year and received an OAHS service.
Numerator	Number of patients with HIV who had at least two visits 90 days apart during the measurement year and received an OAHS service.
Denominator	Number of patients with HIV who had at least one medical visit during the measurement year.
C5 – MT: Medical Transportation	
Description	Percentage of patients with HIV who had at least two medical encounters at least 90 days apart during the measurement year and received medical transportation services.

Numerator	Number of patients with HIV who had at least two medical visits at least 90 days apart during the measurement year and received medical transportation services.
Denominator	Number of patients with HIV who had at least one medical visit during the measurement year.

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.

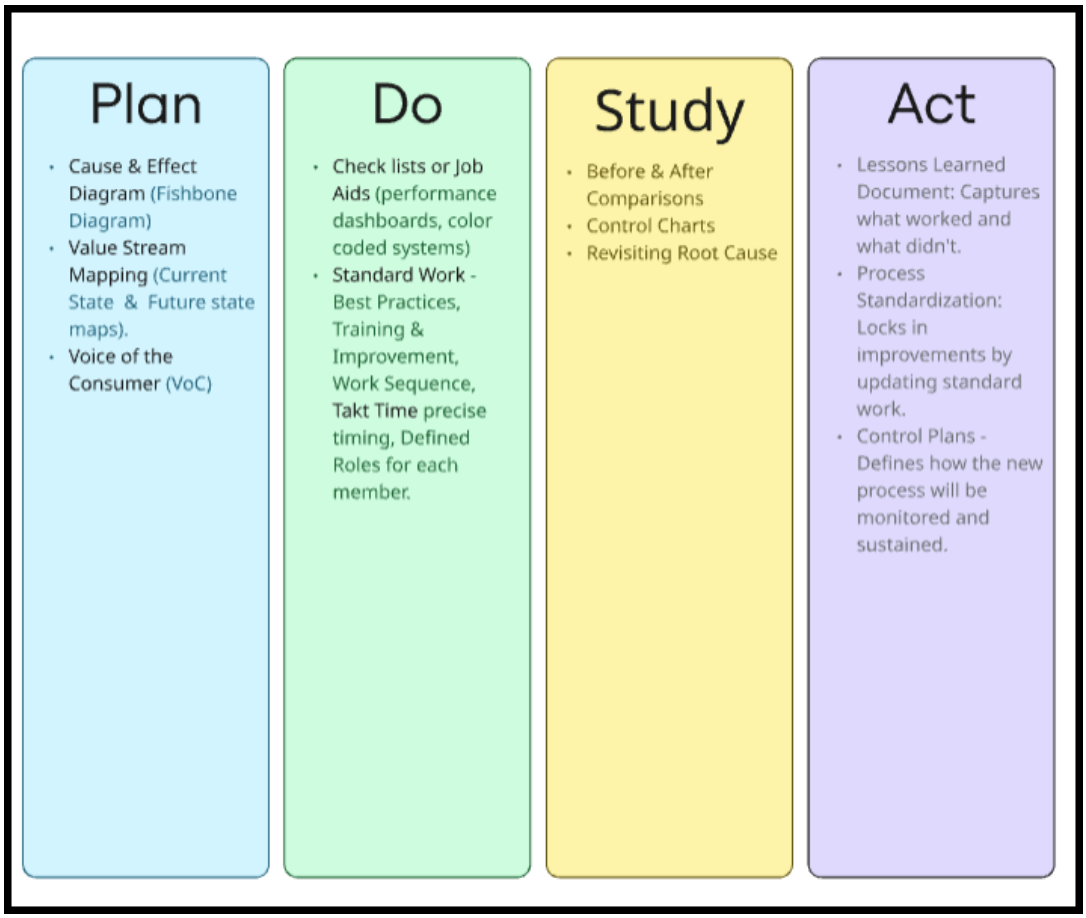
An overview of the Quality Improvement activities that the CQM Advisory Committee has identified is in the table below. This is a "living document" and contains the current and future QI activities. This table will be revised regularly. The table lists the activities, action steps, responsible staff,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

Integration of Lean Six Sigma Tools Within the Quality Improvement Process:

To strengthen the consistency, efficiency, and impact of Quality Improvement (QI) activities, the CQM program will incorporate Lean Six Sigma (LSS) tools within each phase of the Plan, Do, Study Act (PDSA) cycle. The integration of LSS methodologies supports data-driven decision-making, reduces waste, enhances process

reliability, and improves outcomes across all subrecipient agencies. Lean Six Sigma tools will be incorporated into the improvement process as follows:

1. **Plan** – This phase focuses on identifying a problem, understanding root causes, and developing an improvement plan. Subrecipients will define the problem and identify root causes using LSS tools to clearly outline improvement opportunities. This phase results in a well-defined objective and a clear understanding of underlying issues. Tools may include:
    a. Fishbone Diagram – (Cause & Effect)
    b. Value Stream Mapping
    c. Voice of the Consumer
2. **Do** – This phase involves implementing the planned change on a small scale by helping staff identify process steps to add value and eliminate steps that do not. Tools utilized during this phase may include:
    a. Standard Work – Establishes best practices to ensure consistency during testing
    b. Check Lists or Job Aids – Ensures the steps of the test are followed as designed
    c. Visual Management – Make progress and performance visible (ex: boards, signage)
3. **Study** – This phase involves analyzing the results from the small-scale test of change or process. Tools may include:
    a. Before and After Comparisons
    b. Control Charts
    c. Revisiting Root Cause
4. **Act** – This phase includes lessons learned documents that capture what worked and what did not. In addition, this phase includes the development or revision of standardized workflows or control plans that define how the new process will be monitored or sustained.



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, CQM Analyst, EHE Management Analyst, Program Analyst, Compliance Analyst, and SPOCs, meet monthly to discuss updates, challenges, successes, and quality improvement.		Office of HIV Staff, & CQM SPOCs	Jan. - Dec. 2026	
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 14.		CQM SPOCs	**First Cycle:** QIP proposal due April 10, 2026 QIP Cycle ends August 10, 2026 Reporting of Outcomes are due September 10, 2026. **Second Cycle:** QIP proposal due September 10, 2026 QIP Cycle ends December 31, 2026 Reporting of Outcomes are due February 10, 2026.	
CQM Technical Assistance, Training & Capacity Building				
Capacity Building • Review updated PDSA Form • Review 2026 CQM Program Timeline		CQM Analyst CQM SPOCs	March 2026	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 outcome report information.		CQM Analyst	August 2026	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 2026 Service Utilization Data Report to determine PMs that will be monitored.	Clinical Quality Management Analyst	February 2026	The frequency of these reports will be pulled on a quarterly basis.
Increase the LVTGA rate of **linked to care** EIS clients from 67.95% to 72%. Increase the LVTGA rate of **virologically suppressed** MCM clients from 87.79% to 89.0%. Increase the LVTGA rate of **virologically suppressed** OAHS clients from 92.94% to 94.0%. Increase the LVTGA rate of clients MCM retained in care from 63.37% to 67.0%. Increase the LVTGA rate of clients OAHS retained in care from 71.99% to 75.0%. Increase the LVTGA rate of clients MT retained in care from 73.01% to 75.0%. Increase the LVTGA rate of Retained in Care clients Referred for Healthcare and Support Services from 61.54% to 67.0%.	The CQM Analyst will run the LVTGA PM data using CAREWare's Performance Measurement Module.	CQM Analyst	April 2026 July 2026 Oct. 2026 Jan. 2027	The frequency of these reports will be pulled on a quarterly basis. Updates shared at the quarterly CQM meetings in June, September, and January. CQM Analyst will report out performance measurement data at the PC SPA Meetings in June, October and February.

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: September 1, 2026, and February 1, 2027	
Goal 3: Strengthen performance measurement systems to accurately assess patient outcomes and drive targeted improvements.				
Create a Subrecipient Timeline for Reporting 2026	Develop the 2026 subrecipient Timeline for Reporting and integrating the finalized timeline into the annual CQM plan.	CQM Analyst	January 2026	This timeline is on page 14 of this annual CQM plan.
Create a schedule of Quality Quickie and CQM Dates	Finalize and distribute the 2026 Quality Quickie and CQM Committee meeting schedule through calendar invitations.	CQM Analyst	January 2026	Recipient communicated dates via email and calendar invitations.
Individual Capacity Building	Conduct individualized capacity-building sessions (in-person or virtual) to review QIP performance measures and PDSA documentation, and opportunities for improvement.	CQM Analyst & Subrecipients	March - April 2026 Aug. - Sept. 2026	Sessions may be held in person or online. The purpose is to collaboratively identify quality improvement opportunities. SPOCs are responsible for scheduling sessions.
Capacity Building Lab Data Days	Deliver virtual and/or in person capacity-building sessions focused on lab data processes, technical assistance, and reporting support.	CQM Analyst Subrecipients	March 2026 June 2026 Sept. 2026 Dec, 2026	CQM Analyst will provide morning and afternoon sessions to maximize participation.
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	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 Advisory Committee participates in an analysis of the TGA to evaluate the current CQM program.	Part A Project Director, Management Analysts, and CQM SPOCs	Q3	

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, 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 Days on a quarterly basis. Technical assistance, training, and support sessions provided by the Clinical Quality Management Analyst are in person and/or 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.

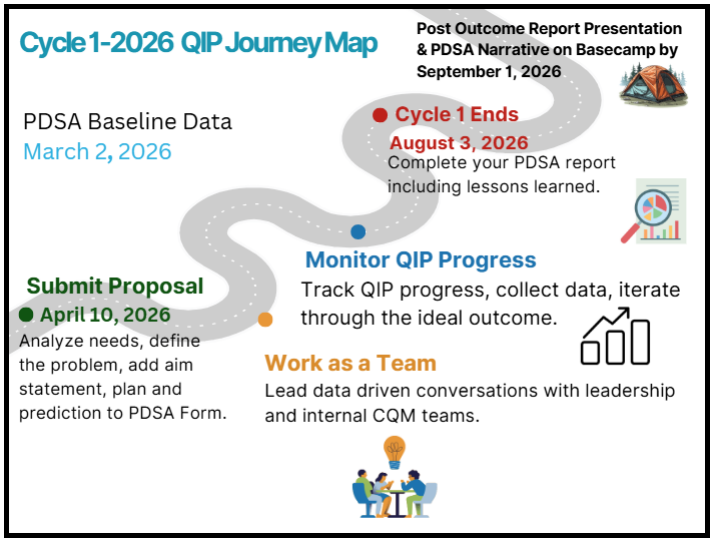
Capacity Building and Technical Assistance Using Lean Six Sigma

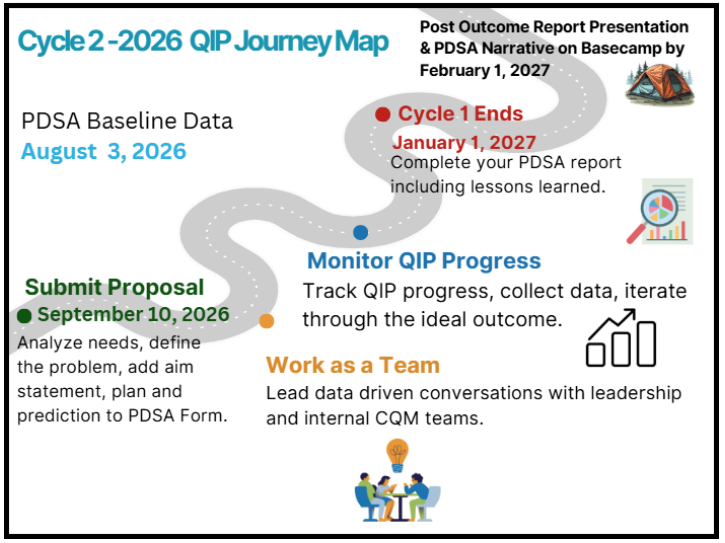
The CQM Program will also integrate Lean Six Sigma (LSS) tools into capacity building and technical assistance efforts. This includes brief training for SPOCs and providers on using basic Lean tools such as process maps, fishbone diagrams, and simple data summaries to support problem identification, interpretation of aggregate reports, and continuous improvement. Lean principles will be incorporated into ongoing technical assistance to reinforce consistent processes, reduce waste, and enhance data-driven decision-making across subrecipient agencies.

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

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 2026		
Cycle 1		**Cycle 2**
QIP Proposal Due April 10, 2026	If the data reporting day falls on a weekend or holiday, the data reporting will be due on the first business day after the weekend or holiday.	QIP Proposal Due September 10, 2026
March 2, 2026		August 3, 2026
April 1, 2026		September 1, 2026
May 1, 2026		October 1, 2026
June 1, 2026		November 1, 2026
July 2, 2026		December 1, 2026
August 3, 2026		January 1, 2027
Cycle 1 Outcomes Report Due September 1, 2026		Cycle 2 Outcomes Report Due February 1, 2027





Quarter	Reporting Focus	Reporting Date
Q1 2026	Performance Measure Updates	April 2026
Q2 2026	Performance Measure Updates	July 2026
Q3 2026	Performance Measure Updates	September 2026
Q4 2026	Performance Measure Updates	January 2027