INDIANA HIV/STD/VIRAL HEPATITIS DIVISION
INTEGRATED CLINICAL QUALITY MANAGEMENT PLAN

October 1, 2022 – September 30, 2023

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The glossary to accompany this document can be found here:
https://www.in.gov/health/files/CQM%20Plan%20Glossary%20of%20Terms.pdf

Quality Statement

Mission Statement for Clinical Quality Management

The mission of the Division of HIV/STD/Viral Hepatitis Clinical Quality Management (CQM) Program is to ensure optimal health outcomes for all Hoosiers by continuously improving the quality of the programs funded by the Division.

Core Values of the CQM Program

- Diversity: Create and maintain an inclusive body of qualified and knowledgeable individuals to inform decision making.
- Integrity: Maintain honest, trustworthy, and transparent communication with all stakeholders in our efforts to achieve optimal public health outcomes.
- Innovation: Encourage innovation to continuously improve our programs and services, engage our workforce, keep pace with community needs, and to utilize scientific data and evidence-based practices to achieve our mission.
- Collaboration: Ensure participation of stakeholders at all levels, including the Indiana Department of Health (IDOH), subrecipients of grant funding, consumers and people with lived experience (PWLE), and the communities we serve.
- Equity: We place equity at the center of our quality improvement work to ensure all Hoosiers, regardless of individual characteristics historically linked to discrimination or exclusion, have access to social and physical supports needed to promote health from birth through end-of-life.

Purpose of the CQM Program

The CQM Program coordinates the Division and subrecipient participation in statewide clinical quality improvement (CQI) projects by providing a performance measurement reporting system and by creating statewide quality improvement (QI) activities. Improvement activities are focused solely on systems and processes, not on individuals or people. The Division Clinical Quality Management Team (CQM Team) is available to subrecipients to facilitate improvement activities and provide any needed coaching or technical assistance.

The Division CQM Program maintains a culture of quality within the Division and among subrecipients through a comprehensive quality management (QM) infrastructure (i.e., QM plan, dedicated staff, dedicated resources, and stakeholder engagement). Improving processes within Division programs will result in improved health outcomes for not only consumers of Division-funded services but for all Hoosiers across the state.

2022-2023 CQM Priorities:

VIRAL SUPPRESSION AMONG PEOPLE LIVING WITH HIV IN INDIANA (PLWH)

Increasing the percentage of the Services Program's consumers who achieve viral suppression will be the focus of HIV Services for the CQM Program. Statewide and nationally, there has been an emphasis placed on increasing viral suppression, as recent research has shown that an undetectable viral load prevents transmission of the virus.

PREVENTION OF NEW HIV AND STD INFECTIONS

The CQM Program will ensure that prevention efforts are guided by the High-Impact Prevention Approach endorsed by the Centers for Disease Control and Prevention (CDC). HIV and STD prevention CQI activities will focus on promoting overall efficiency and appropriate population prioritization in all Prevention Programs funded by the Division.

STD PREVENTION THROUGH DISEASE INTERVENTION

Provide on-the-ground prevention support aimed at increasing the capacity of organizations housing disease intervention specialists (DIS) funded by the STD Prevention Program to improve the quality and outcomes of their services.

DATA-INFORMED VIRAL HEPATITIS PROGRAMS

The Viral Hepatitis Program will maximize its current resources to streamline and increase data collection that will be used to assess need and implement new policies/programs addressing said needs.

COLLABORATION WITH PWLE AND COMMUNITY-BASED PARTNERS

The ZIP Coalitions across the state provide additional infrastructure for voices of PWLE, traditional, and non-traditional providers to be elevated. The CQM Program will prioritize collaborations with coalitions and their members by providing added support on QI initiatives to address barriers and increase regional capacity and collaboration.

ADDRESSING STIGMA SURROUNDING HIV, STD, AND VIRAL HEPATITIS

Research indicates that stigma surrounding HIV, STD, and viral hepatitis reduces the likelihood that a person will engage in harm reduction practices as well as treatment or medical management. The CQM Program will focus on further understanding the role that stigma plays in Indiana and explore interventions that further validate and de-stigmatize the experiences of people living with HIV, STD, and viral hepatitis.

Quality Infrastructure

Leadership

The Indiana Department of Health (IDOH) is a recipient of the Ryan White HIV/AIDS Program (RWHAP) (Part B grant) and CDC Prevention Funds. IDOH administers these grants through the Division of HIV/STD/Viral Hepatitis.

Within the Division, the Services Program is responsible for ensuring administration of the RWHAP grant, including adherence of the Division CQM plan. The Division CQM plan will be developed by the COC Quality Manager in the Clinical Quality Management and Community Impact Program. As a Part B recipient, IDOH is required to develop and oversee the statewide planning and QI processes. These efforts aim to identify and address the most significant needs of PLWH and to maximize coordination, integration, and effective linkage across the Ryan White-funded services in Indiana.

With the support of the Division Director, the CQM Team will be responsible for overall leadership of the Division CQM Program.

Job Duties	COC Quality Manager and associated team members
Write and edit CQM Plan	
Collecting Services, Prevention, and Surveillance Program Data	
Calculating performance measure results	
Updating QM work plan (quarterly)	
Prepare report on data findings	
Coordinating the design and implementation of CQI projects	
Facilitating quality improvement activities	
Engaging funded sites in CQM Program activities	
Coordinating QM training for Division staff and subrecipients	
Coordinating the internal CQM Committee	
Coordinating the external CQM Committee	
Monitoring progress towards goals/objectives outlined in the Statewide HIV Integrated Plan	
Evaluate subrecipient CQM programs	
Provide technical assistance to subrecipient CQM programs	

*Shaded boxes indicate assigned responsibilities.

Clinical Quality Management Committees

Two committees advise the CQM Program. The purpose of these two Committees is to serve as advisors to the CQM Program regarding performance measure evaluation and QI activities across the Division's prevention, services, and surveillance systems of care.

MEMBERSHIP

CQM Committee members will be recruited from both internal and external stakeholders. The Internal CQM Committee has representation from each program within the Division. Their membership on the committee must be approved by their program directors. The External CQM Committee is a standing subcommittee of the HIV/STD Advisory Council. Members of that committee are representative of the programming funded by the Division across the state of Indiana. Consumers on the External Committee are chosen to represent each region of the state (Northern, Central, and Southern). Membership will be reviewed annually. There are no term limits on membership.

The Internal and External CQM Committee Member Matrices are located in the appendix.

RESPONSIBILTIES OF MEMBERS

It is expected that Internal Committee members will use their position on the committee to provide feedback and input that has the support of their program director and team. External Committee members will use their position on the committee to provide feedback and input that has the support of the organization they represent.

CQM Committee Responsibilities	Internal Committee	External Committee
Actively participate in meetings, conference calls, and other activities		
Review performance measure results and identify trends		
Advise performance measures and indicators to assess and improve performance		
Review and advise on updates to the CQM plan annually		
Advise the CQM plan for the subsequent year		
Advise CQM Program evaluation		
Participate in CQM and QI trainings		
Advise on internal QI projects for the Division		
Advise on QI project recommendations		
Act as a liaison between program areas and the CQM Program		

*Shaded boxes indicate assigned responsibilities.

MEETINGS

The External CQM Committee will meet bi-monthly, in person or virtually. Meetings will be held at IDOH on the mornings before each HIV/STD Advisory Council meeting. Video conferencing and/or conference calls will be scheduled, as needed, between meetings. CQM Committee members should make every effort to attend meetings in-person or virtually.

The Internal CQM Committee will meet in-person or virtually each month.

Stakeholder Involvement

Stakeholders of the Division CQM Program include Services subrecipients and Prevention subrecipients. Their roles and responsibilities include:

- Participating in Zero Is Possible (ZIP) Coalitions,
- Participating in the HIV/STD Advisory Council,
- Contributing to Statewide QI projects,
- Creating and implementing QM programs, and
- And keeping accurate and current data in data systems provided by the Division.

Consumer and PWLE Involvement

In alignment with the CQM Program's core values of collaboration and transparency, it is essential to gain input from consumers and PWLE. Consumers and PWLE will be involved in the CQM Program through the following mechanisms:

- **ZIP Coalitions and HIV/STD/Viral Hepatitis Advisory Council–** Consumer and PWLE representation on ZIP Coalitions and the HIV/STD/Viral Hepatitis Advisory Council is essential to ensure that their voices and experiences are centered and guide regional and statewide planning efforts.
- **Consumer Needs Assessment** – Every other year, the Division CQM Program will conduct a statewide Consumer Needs Assessment. This Consumer Needs Assessment will be available to PLWH in Indiana. The Consumer Needs Assessment will serve as an additional mechanism to solicit ideas, solutions, and suggestions for the CQM Program.
- **External CQM Committee** –To ensure that consumer voices can be heard and considered when creating survey and need assessment tools, consumers are represented on the External CQM Committee.
- **Consumer Engagement in QI Projects** – Consumers are engaged to guide and inform QI projects via focus groups and participation on QI project planning groups.

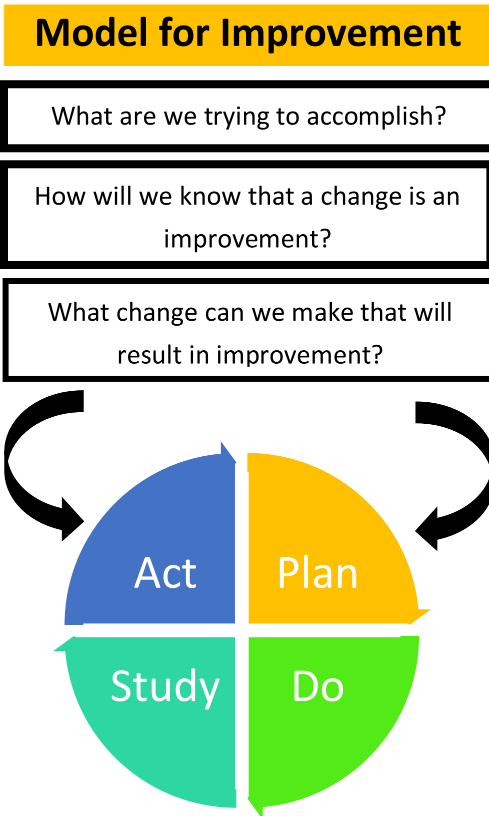
Performance Measures

Performance measurement is a method that will be used to identify and quantify the critical aspects of the programs under the scope of the CQM Program and the Division. Measuring key components of the programs not only creates a valuable source of data regarding the programs' greatest areas of success, but also identifies those areas that require improvement. However, it is equally important for performance measurements to identify those areas that will produce the greatest benefit by quality improvement. In an increasingly complex health care environment, a system for routine performance measurement is essential. All measures are prioritized based on relevance, measurability, accuracy, and improvability. All relevant HIV/AIDs Bureau (HAB) measures will be utilized for RWHAP funded categories. Non-RWHAP funded program measures are selected based on the priorities of those programs and their funders. Performance measures are reviewed by the Internal and External CQM Committees. All suggestions and edits are taken under consideration by the CQM Team. The method described in HRSA Policy Clarification Notice 15-02 will be utilized to determine the amount of performance measures analyzed for each service category.

The performance measures and their data sources that have been selected to be monitored by the CQM Program can be found in the appendix.

Quality Improvement

Clinical Quality Improvement Projects



CQI Projects and their activities are determined by using the qualitative and quantitative data available to the CQM Program and through stakeholder involvement at multiple levels. The CQM team uses available data to drive priority setting for QI Project aims. The CQM team works with the Internal CQM Committee to generate CQI project ideas through root cause analysis. The External CQM Committee assists in generating change ideas that address previously identified root causes. Both committees will review data, help with implementation, and provide guidance to circumvent problems that may appear. Overall, the CQM Program will utilize the Model for Improvement (pictured on the left) as the framework to guide its improvement work.

Quality Improvement Project: Community Health Improvement Initiative

Black women are disproportionately at risk of acquiring HIV and STDs. While black women accounted for 10% of the 430 new Indiana HIV diagnoses in 2020, these diagnoses represent 53% of new diagnoses in all women. Black women were 13.3 times more likely to be diagnosed with HIV than the general population. The same year, black women experienced increased rates of chlamydia (4.6), gonorrhea (4.4), and syphilis (1.5). Black women also experience increased health disparities when it comes to achieving a suppressed HIV viral load. In 2020, black women had the second lowest viral load suppression when compared to other demographic groups.

The Community Health Improvement Initiative: Black Women (CHII: Black Women) is a 13-month initiative that brings together HIV/STD treatment and prevention organizations, as well as other community-based organizations that serve black women in high prevalence regions, in an effort to reduce HIV disparities experienced by black women. Learning will take place in the form of teaching conducted by subject matter experts, engaging activities planned by the learning initiative faculty to reinforce learning, and assistance with planning the implementation of applying best practices identified during the initiative. The overall goals of CHII: Black Women are detailed below.

Goal #1: Improve Health Equity- The CQM Program seeks to reduce HIV related disparities and health inequities. The CQM Program will work with subrecipients serving the largest number of black women to cultivate environments of quality with focus on increasing viral suppression and decreasing new HIV infections.

Goal #2: Prioritization of HIV, STD, and HCV Testing- In recent years, the CDC has placed an emphasis on high-impact prevention, which stresses the value of efficient and effective programs that prioritize populations and regions with the highest need. The CQM Program will work to ensure that subrecipients have access to local data and use that data to prioritize populations at the highest risk for HIV, Hepatitis C, and STDs in their geographical regions.

Quality Improvement Project: Increasing Viral Load Suppression through Linkage and Retention in Care

Connecting people who are newly diagnosed to HIV medical care and ensuring that they have the necessary resources to continue care is foundational to ending the HIV epidemic. While in 2021, ___ % of people who are newly diagnosed in Indiana are connected to care within 30 days, however, disparities exist across the state. Furthermore, there was at least ___ PLWH across the state that are no longer engaged in medical care in 2021. The Services Program understands the importance of ensuring that all PLWH are given the opportunity to engage in medical care. The Services Program will work with the CQM Program to assess state-wide efficacy and implement strategies to increase timely linkage of individuals who are newly diagnosed as well as increase the number of individuals re-engaged in medical care. The goals of this initiative are found below:

Goal #1: Increasing Viral Load Suppression through Timely Linkage to Care – The Services Program will assess state-wide efficacy in linking new diagnoses to HIV medical care and implement strategies to increase the timely linkage of individuals who are newly diagnosed.

Goal #2: Increasing Viral Load Suppression through Lost to Care Services – The Services Program will assess the efficacy of the L2C Program and work and implement strategies to increase the number of individuals linked back to care.

Goal #3: Assessing Life Outcome Indicators – The Services Program will assess using life outcome indicators, such as client stability or quality of life, to see if they correlate or predict an individual’s likelihood of becoming virally suppressed.

Subrecipient Quality Improvement Projects

Subrecipients are required to submit quarterly QI project reports to the IDOH CQM Team utilizing the QI Project Report Form found in the resource section here: https://www.in.gov/health/hiv-std-viral-hepatitis/quality-management/ The 2022-2023 reporting schedule can be found in the table below.

Quarter	Report Due Date
1	December 31, 2022
2	March 31, 2023
3	June 30, 2023
4	September 30, 2023

Evaluation

The following types of evaluation will be used to review the CQM Program:

- Target Center Part B Organizational Assessment Tool (https://www.in.gov/isdh/files/Organizational%20Assessment%20tool%20Part%20B.pdf) – This will be completed annually in August by the CQM Team.
    - The CQM Team will use the pre-OA evaluation checklist in July, prior to drafting the next year's CQM plan.
- CQM Team self-assessment – This will include evaluation of the work plan to assess the efficacy of the CQM Program. This will be, at a minimum, once in July by the CQM Team.

CQI projects will be evaluated by the CQM Team, and both CQM Committees to assess the effectiveness and success of the project.

Updating the CQM Plan

Annually in August, the CQM Team will review the CQM Plan and make any needed revisions. The CQM Team will then create a draft of the CQM Plan for the following year. The draft will be presented to the Internal and External CQM Committees for their review and suggestions. Then the CQM Team will make final edits based on the advisement from both committees. Following final revisions, the plan will be sent to the Division Director for final signature of support.

Capacity Building

The Quality Management Team will provide technical assistance and trainings on CQM and seek to build a culture of quality internally at IDOH and at all funded care sites. It is essential to engage subrecipients as part of the CQM process.

Technical assistance visits are conducted on a yearly basis (or upon request) with all subrecipients. At those visits, subrecipients are provided binders with performance and health outcome data, as well as CQM resources. Subrecipients are also provided with information about how their CQM Program will be evaluated by IDOH. The content of these binders can also be found online at https://www.in.gov/health/hiv-std-viral-hepatitis/quality-management/.

Communication and Information Sharing

The CQM Program recognizes the importance of communicating feedback about all performance measures. The CQM Program will offer a variety of media types to be utilized for information sharing including but not limited to reports and infographics. Reports for statewide performance measures will be dispersed to all funded subrecipients quarterly and will include all data points captured for the previous quarter. The CQM Program will share programmatic updates, including but not limited to QI project progress, performance measures data update, and subrecipient progress on QI initiatives, on a quarterly basis with the HIV/STD/HCV Advisory Board, ZIP Coalitions, and/or any other key bodies of stakeholders. Pertinent resources and materials will also be shared on the Division's website https://www.in.gov/health/hiv-std-viral-hepatitis/quality-management/.

Reports

Performance measurement data will be sent to all subrecipients/stakeholders each quarter and may contain any of the performance measures listed in the appendix. The data should be used for the purposes of sharing best practices with other organizations and identifying opportunities for improvement around the state.

The HIV/STD/Viral Hepatitis CQM plan has been approved by the CQM Team and HIV/STD/Viral Hepatitis Division leadership. The plan is effective from 10/01/2022 until 09/30/2023.

Appendix

Performance Measures

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
Services Program	Statewide HIV Viral Load Suppression	**Description:** Percentage of consumers, regardless of age, with a diagnosis of HIV and a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement period. **Numerator:** Number of consumers in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement period. **Denominator**: The number of consumers, regardless of age, with a diagnosis of HIV and at least one medical visit in the measurement period. **Exclusions**: Consumers diagnosed with HIV during the measurement period and consumers who died during the measurement period.	• Race/Ethnicity: ○ White ○ African American/Black ○ Hispanic • Risk Factor: ○ MSM ○ AA ○ White ○ Hispanic ○ IDU • Gender: ○ Women ○ Transgender ○ MTF ○ FTM • Age: ○ 13-24 ○ 25-34 ○ 35-44 ○ 45-54 ○ 55-64 ○ 65+	**Measurement Period**: 12 months **Reporting Frequency**: Quarterly **Target**: 70% **Baseline:** 68%	**eHARS**

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
			• Diagnosed with HIV outside of the US		
	Application Determinatio n (ADAP)	**Description:** Percent of ADAP applications approved or denied for new* ADAP enrollment within 14 days (two weeks) of ADAP receiving a complete application in the measurement period. **Numerator:** Number of applicants that were approved or denied for new ADAP enrollment within 14 days of ADAP receiving a complete application in the measurement period. **Denominator:** The total number of complete ADAP applications for new ADAP enrollment received in the measurement period. **Exclusions:** 1. ADAP applications for new ADAP enrollment that were incomplete or incorrectly filled out. 2. Complete ADAP applications for new ADAP enrollment received by ADAP within the last 14 days of the measurement period. *New ADAP enrollment refers to individuals who applied to ADAP for the first time ever.		**Measurement Period**: 12 months **Reporting Frequency**: Yearly **Target**: 92% (National Target) **Baseline:** 81%	**RWISE**
	Medicaid Eligible Consumers	**Description:** Percentage of consumers enrolled in ADAP/EIP who may be eligible for Medicaid.	• By percent FPL ○ ≤ 138% to 101% ○ ≤ 100% to 51%	**Measurement Period:** 12 months	**RWISE**

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
	Enrolled in ADAP/EIP (ADAP)	**Numerator:** Number of consumers in the denominator whose last reported annual income is at or below 138% federal poverty level (FPL). **Denominator**: Number of consumers enrolled in ADAP/EIP during the measurement period. **Exclusion:** Consumers approved for new ADAP/EIP enrollment during the measurement period and consumers categorically ineligible for Medicaid or other government funded health coverage options.	○ ≤ 50% to 1% 0%	**Reporting Frequency:** Quarterly **Target:** TBD **Baseline:** TBD	
	Retention in Non-Medical Case Management Services (NMCM)	**Description:** Percentage of consumers who received non-medical case management and are retained in non-medical case management services during the measurement period. **Numerator:** The number of consumers in the denominator who are retained* in non-medical case management services. **Denominator:** Number of consumers who had at least one non-medical case management service during the measurement period.	• Race/Ethnicity: ○ White ○ African American/Black ○ Hispanic • Risk Factor: ○ MSM ○ AA ○ White ○ Hispanic ○ IDU • Gender: ○ Women ○ Transgender ○ MTF	**Measurement Period**: 12 months **Reporting Frequency**: Yearly **Target**: 94% **Baseline:** 92.3%	**CAREWare**

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
		Exclusions: Consumers who are closed out in CAREWare by their non-medical case management site during the measurement period. *Retained in non-medical case management services means that the consumer received at least one (1) non-medical case management service during the first six months of the measurement period and at least one (1) non-medical case management service during the last six months of the measurement period.	◦ FTM • Age: ◦ 13-24 ◦ 25-34 ◦ 35-44 ◦ 45-54 ◦ 55-64 • 65+		
	Housing Status (NMCM)	**Description:** Percentage of consumers with a HIV diagnosis who were homeless or unstably housed during the measurement period. **Numerator:** The number of consumers in the denominator who were homeless or unstably housed during the measurement period. **Denominator:** Number of consumers with an HIV diagnosis who had at least one non-medical case management service in the measurement period. **Exclusions**: Consumers diagnosed with HIV during the measurement period and consumers who died during the measurement period.	• Race/Ethnicity: ◦ White ◦ African American/Black ◦ Hispanic • Risk Factor: ◦ MSM ◦ AA ◦ White ◦ Hispanic ◦ IDU • Gender: ◦ Women ◦ Transgender ◦ MTF ◦ FTM • Age: ◦ 13-24 ◦ 25-34	**Measurement Period**: 12 months **Reporting Frequency**: Yearly **Target**: TBD **Baseline:** TBD	**CAREWare**

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
			○ 35-44 ○ 45-54 ○ 55-64 • 65+		
	HIV Viral Load Suppression (HSP)	**Description:** Percentage of consumers, regardless of age, with a diagnosis of HIV and a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement period. **Numerator:** Number of consumers in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement period. **Denominator**: The number of consumers, regardless of age, with a diagnosis of HIV who completed the recertification/referral for a program within HSP during the measurement period. **Exclusions**: Consumers diagnosed with HIV during the measurement period and consumers who died during the measurement period.	• By subrecipient • By HSP Program ○ Services ○ HIAP ○ HIP Basic ○ HIP Plus ○ MDAP ○ ADAP + EIP ○ Delta Dental • State-funded NMCM only	**Measurement Period**: 12 months **Reporting Frequency**: Yearly **Target**: TBD **Baseline:** TBD	**CAREWare & eHARS**
	HIV Viral Load Suppression (NMCM)	**Description:** Percentage of consumers, regardless of age, with a diagnosis of HIV and a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement period.	• Race/Ethnicity: ○ White ○ African American/Black ○ Hispanic • Risk Factor:	**Measurement Period**: 12 months **Reporting Frequency**: Yearly **Target**: 85%	**CAREWare & eHARS**

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
		Numerator: Number of consumers in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement period. **Denominator**: The number of consumers, regardless of age, with a diagnosis of HIV who had at least one non-medical case management service during the measurement period. **Exclusions**: Consumers diagnosed with HIV during the measurement period and consumers who died during the measurement period.	○ MSM ○ AA ○ White ○ Hispanic ○ IDU • Gender: ○ Women ○ Transgender ○ MTF ○ FTM • Age: ○ 13-24 ○ 25-34 ○ 35-44 ○ 45-54 ○ 55-64 • 65+	**Baseline:** 83%	
	HIV Viral Load Suppression (MCM)	**Description:** Percentage of consumers, regardless of age, with a diagnosis of HIV and a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement period. **Numerator:** Number of consumers in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement period. **Denominator**: The number of consumers, regardless of age, with a diagnosis of HIV who had at least one non-medical case	• Race/Ethnicity: ○ White ○ African American/Black ○ Hispanic • Risk Factor: ○ MSM ○ AA ○ White ○ Hispanic ○ IDU • Gender: ○ Women ○ Transgender	**Measurement Period**: 12 months **Reporting Frequency**: Yearly **Target**: 85% **Baseline:** 83%	**CAREWare & eHARS**

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
		management service during the measurement period. **Exclusions**: Consumers diagnosed with HIV during the measurement period and consumers who died during the measurement period.	○ MTF ○ FTM • Age: ○ 13-24 ○ 25-34 ○ 35-44 ○ 45-54 ○ 55-64 • 65+		
	HIV Viral Load Suppression (FB/HDM)	**Description:** Percentage of consumers, regardless of age, with a diagnosis of HIV and a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement period. **Numerator:** Number of consumers in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement period. **Denominator**: The number of consumers, regardless of age, with a diagnosis of HIV who had at least one food bank service in the measurement period. **Exclusions**: Consumers diagnosed with HIV during the measurement period and consumers who died during the measurement period.	• By subservice: ○ Food Bank ○ Food Voucher • Non-Prescribed Home Delivered Meals	**Measurement Period**: 12 months **Reporting Frequency**: Biannually **Target:** 91% **Baseline:** 88.3%	**CAREWare & eHARS**
	HIV Viral Load Suppression	**Description:** Percentage of consumers, regardless of age, with a diagnosis of HIV and	• By subservice: ○ Food	**Measurement Period**: 12 months	**CAREWare & eHARS**

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
	(EFA)	a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement period. **Numerator:** Number of consumers in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement period. **Denominator**: The number of consumers, regardless of age, with a diagnosis of HIV who had at least one emergency financial assistance service in the measurement period. **Exclusions**: Consumers diagnosed with HIV during the measurement period and consumers who died during the measurement period.	○ Utilities • Housing	**Reporting Frequency**: Biannually **Target**: TBD **Baseline:** TBD	
	HIV Viral Load Suppression (MNT)	**Description:** Percentage of consumers, regardless of age, with a diagnosis of HIV and a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement period. **Numerator:** Number of consumers in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement period.	• By subservice: ○ Assessment or Education Visit ○ Prescribed Home Delivered Meal • Nutritional Supplements	**Measurement Period**: 12 months **Reporting Frequency**: Biannually **Target:** 91% **Baseline:** 89.7%	**CAREWare & eHARS**

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
		Denominator: The number of consumers, regardless of age, with a diagnosis of HIV who received at least one medical nutritional therapy service unit in the measurement period.			
	Viral Hepatitis Services Program Enrollment	**Description:** The percentage of consumers referred to the Viral Hepatitis Services Program who also enrolled in the program. **Numerator:** The number of consumers from the denominator who enrolled in the Viral Hepatitis Service Program during the measurement period. **Denominator:** The number of consumers referred to the Viral Hepatitis Services Program during the measurement period.		**Measurement Period:** 12 months **Reporting Frequency:** Quarterly **Statewide Target:** TBD **Statewide Baseline:** TBD	**Aphirm**
	Re-Linkage to HIV Medical Care (L2C DIS)	**Description:** The percentage of previously diagnosed HIV cases determined to be out of care assigned to a DIS who attended a routine HIV medical visit within 30 days of assignment to the L2C DIS. **Numerator:** The number of cases from the denominator who attended a routine HIV medical visit within 30 days of assignment to the L2C DIS. **Denominator:** The number of previously diagnosed HIV cases determined to be out of	• By STD district	**Measurement Period:** 12 months **Reporting Frequency:** Quarterly **Baseline:** TBD **Target:**	**NBS/EHARS**

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
		Care* that are assigned to L2C DIS* during the measurement period. *Note: See Linkage to Care Standard Operating Procedure for "Out of Care" definition.			
Prevention Program	HIV Testing in Priority Populations	**Description:** The percentage of IDOH-funded test events performed on individuals in priority populations (at least one of the following risk factors/groups: IDU, MSM, AA women, Hispanic women, youth ages 15-29, transgender individuals) during the measurement period. **Numerator:** The number of IDOH-funded HIV test events from the denominator performed on individuals in a priority population (at least one of the following risk factors/groups: IDU, MSM, AA women, Hispanic women, youth ages 15-29, transgender individuals) during the measurement period. **Denominator:** The number of IDOH-funded HIV test events performed during the measurement period.	• By subrecipient	**Measurement Period:** 12 months **Reporting Frequency:** Quarterly **Target:** 70% **Baseline:** 68%	**Aphirm**
	HIV Positivity Rate	**Description:** The percentage of IDOH-funded HIV test events resulting in a new diagnosis. **Numerator:** The number of IDOH-funded HIV test events from the denominator resulting in a new HIV diagnosis.	• By subrecipient	**Measurement Period:** 12 months **Reporting Frequency:** Quarterly **Statewide Target:**	**Aphirm**

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
		Denominator: The number of IDOH-funded HIV test events performed within the measurement period.		0.61% **Statewide Baseline:** 0.47%	
	Linkage to HIV Medical Care (HIV Testing Sites)	**Description:** The percentage of consumers, regardless of age, with a new HIV diagnosis originating from an IDOH-funded HIV test event who attended a routine HIV medical visit within 1 month of HIV diagnosis. **Numerator:** The number of consumers from the denominator who attended a routine HIV medical visit within 1 month of HIV diagnosis. **Denominator:** The number of consumers, regardless of age, with a new HIV diagnosis originating from an IDOH-funded HIV test event.	• By subrecipient	**Measurement Period:** 12 months **Reporting Frequency:** Quarterly **Statewide Target:** TBD **Statewide Baseline:** TBD	**Aphirm & eHARS**
	Linkage to HIV Medical Care (DIS)	**Description:** The percentage of newly diagnosed HIV cases assigned to a DIS who attended a routine HIV medical visit within 1 month of HIV diagnosis. **Numerator:** The number of cases from the denominator who attended a routine HIV medical visit within 1 month of HIV diagnosis. **Denominator:** The number of newly diagnosed HIV cases assigned to DIS during the measurement period.	• By STD district	**Measurement Period:** 12 months **Reporting Frequency:** Quarterly **Baseline:** **Target:**	**NBS/EHARS**

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
	Percent of Chlamydia Cases with CDC-Recommended Treatment	**Description:** The percentage of chlamydia cases treated with CDC-recommended treatment during the measurement period. **Numerator:** Number of cases from the denominator that received CDC-recommended treatment. **Denominator:** All confirmed cases of chlamydia during the measurement period.	• By STD district • By CT/GC site that does not provide on-site treatment	**Measurement Period:** Quarterly **Reporting Frequency:** Biannually **State Baseline:** 78% **State Target:** 80%	**NBS**
	Percent of Gonorrhea Cases with CDC-Recommended Treatment	**Description:** The percentage of gonorrhea cases treated with CDC-recommended treatment during the measurement period. **Numerator:** Number of cases from the denominator that received CDC-recommended treatment. **Denominator:** All confirmed cases of gonorrhea during the measurement period.	• By district • By CT/GC sites that does not provide on-site treatment	**Measurement Period:** Quarterly **Reporting Frequency:** Biannually **State Baseline:** 78% **State Target:** 80%	**NBS**
	Percent of Syphilis Cases with CDC-Recommended Treatment	**Description:** The percentage of syphilis cases treated with CDC-recommended treatment during the measurement period. **Numerator:** Number of cases from the denominator that received CDC-recommended treatment.	• By district	**Measurement Period:** Quarterly **Reporting Frequency:** Biannually **State Baseline:** 78% **State Target:** 80%	**NBS**

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
		Denominator: All probable and confirmed cases of syphilis during the measurement period.			
			•		
			•		
Surveillance Program	Acute Hepatitis Surveillance Investigation Completion	**Description**: Percent of acute investigations with completed and submitted to the CDC within 90 days. **Numerator**: Number from the denominator that have been submitted to the CDC within 90 days of case creation date. **Denominator**: The total number of acute and chronic hepatitis B and C cases during the measurement period.		**Measurement Period:** 12 months **Reporting Frequency:** Quarterly **Target:** TBD **Baseline:** 6.62%	**NBS**
	HIV Risk Factor Ascertainmen t	**Description:** The percentage of new HIV cases reported to eHARS that have sufficient risk factor information to be diagnosed into a known HIV transmission category. **Numerator:** The number of cases from the denominator that have sufficient risk factor information to be classified into a known HIV transmission category. **Denominator:** The number of HIV cases newly reported to eHARS during the measurement period.		**Measurement Period:** 12 months **Reporting Frequency:** Quarterly **Baseline:** TBD **Target:** 80%	**EHARS**

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
	eHARS HIV Case Reporting	**Description:** The percentage of new HIV cases that were entered into eHARS within 30 days of the date of diagnosis. **Numerator:** The number of cases from the denominator that were entered within 30 days of the date of diagnosis. **Denominator:** The number of new HIV cases whose diagnoses were entered into eHARS during the measurement period.		**Measurement Period:** 12 months **Reporting Frequency:** Quarterly **Baseline:** TBD **Target:** 75%	**EHARS**
	Gonorrhea Anatomic Site of Infection Reporting	**Description:** The percentage of reported gonorrhea diagnoses* with anatomic site of infection noted in the case investigation. **Numerator:** The number of diagnoses from the denominator with reported anatomic site of infection. **Denominator:** The number of gonorrhea diagnoses during the measurement period. *Gonorrhea diagnoses are de-duplicated so that only one diagnosis per patient within a 30-day timeframe has an investigation. Other cases opened in error are closed due to being considered the "same infection".	• By STD district	**Measurement Period:** 12 months **Reporting Frequency:** Quarterly **Baseline:** TBD **Target:**	**NBS (Use of "Specimen Source" or other related variables in back-end)**
Clinical Quality Management and					

Division Program	Performance Measure (Service Category)	Operational Definition	Disparity Evaluation	Measurement Period, Reporting Frequency, and Target	Data Source
Community Improvement Program					

Detailed Work Plan

Action Item	Description	Responsible Party	Timeframe	Comments/Updates
Calculate performance measure results for the Inclusive CQM Program	Performance measure results will be calculated from data extracted from the CAREWare, RWISE, Aphirm, NBS, and other sources. A list of performance measures can be found in the appendix.	COC Quality Manager and associated team members	Quarterly	
Prepare and distribute Data Feedback Reports to HSP and HIV/STD Prevention Subrecipients	Data Feedback Reports will be compiled and distributed to each HSP and HIV/STD subrecipients. Performance measures and additional data to be included in the report can be found within the CQM Plan.	COC Quality Manager and associated team members	Bi-yearly	
Schedule Internal CQM Committee Meetings	Internal CQM Committee meetings will occur once per quarter	COC Quality Manager and associated team members	Monthly	
Prepare Internal CQM Committee meeting agendas	Topics of discussion for each Internal CQM committee meeting will be determined along with identifying, collecting, and/or preparing data or documents.	COC Quality Manager and associated team members	Monthly	
Prepare Internal CQM Committee meeting minutes	Record notes during Internal CQM Committee meetings, format notes and distribute meeting minutes.	Internal CQM Committee Scribe	Monthly	

Schedule External CQM Committee Meetings	External CQM Committee meetings will occur once per quarter	COC Quality Manager and associated team members	Bi-monthly	
Prepare External CQM Committee meeting agendas	Topics of discussion for each External CQM committee meeting will be determined along with identifying, collecting, and/or preparing data or documents.	COC Quality Manager and associated team members	Bi-monthly	
Prepare External CQM Committee meeting minutes	Record notes during CQM Committee meetings, format notes and distribute meeting minutes.	External CQM Committee Scribe	Bi-monthly	
Review performance measure results	Analyze performance measure results for the CQM Program.	COC Quality Manager and associated team members	Quarterly	
Develop CQI projects	Design CQI projects from performance measure results. Internal and External CQM Committees will aid in developing statewide CQI projects.	COC Quality Manager and associated team members	Ongoing – As Needed	
Implement CQI projects	Work with subrecipients to implement CQI projects. Internal and External CQM Committees will aid in implementation of statewide CQI projects.	COC Quality Manager and associated team members	Ongoing – As Needed	
Evaluate CQI projects	Assess the success of CQI projects. Internal and External CQM Committees will assist in the evaluation of statewide CQI projects.	COC Quality Manager and associated team members	Ongoing – As Needed	

Provide trainings to subrecipients.	Develop and deploy trainings for subrecipients on data, CQI and building a culture of quality.	COC Quality Manager and associated team members	Ongoing – as needed	
Identify priority populations	Work with ZIP Coalitions to identify priority population(s) to focus their viral suppression efforts, if applicable.	COC Quality Manager and associated team members	Ongoing – as needed	
Identify priority testing populations	Work with ZIP Coalitions to identify priority population(s) to focus their testing efforts, if applicable	COC Quality Manager and associated team members	As needed	
Review CQI reports submitted by subrecipients	Review CQI activity report at subrecipient sites undertaken during the year	COC Quality Manager and associated team members	Quarterly	
Conduct site/TA visits	Review and evaluate CQM programs and their activities at subrecipient sites, provide technical assistance and resources necessary at each site.	COC Quality Manager and associated team members	Yearly	

CQM Committee Matrices

External CQM Committee Member Matrix	Internal CQM Committee Member Matrix
COC Quality Manager	COC Quality Manager
Clinical Quality Management and Community Impact Program Director	Clinical Quality Management and Community Impact Program Director
People with Lived Experience (PWLE) a. North b. Central c. South	Services Staff (2)
Services Subrecipient a. North b. Central c. South	Prevention Staff (2)
Prevention Subrecipients (2)	Surveillance Staff (3)
DIS (1)	Clinical Quality Management and Community Impact Staff (1)
Marion County Part A and Damien Center Part C representative (2)	