**HEALTH PLUS INDIANA**

 **Integrated Clinical Quality Management Plan**

**January 1, 2024-December 31, 2024**

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# Quality Culture

## Mission Statement for Clinical Quality Management

The Mission of the Health Plus Indiana (HPI) Clinical Quality Management (CQM) Program is to ensure optimal health outcomes in Northern Indiana by constantly improving the quality of the programs.

**Core Values of the CQM Program**

* **Diversity:** Engage an inclusive group of knowledgeable and experienced employees and stakeholders to improve the quality of programming.
* **Integrity:** Maintain honesty, trust, and transparency as services and programs are improved to ensure optimal health for clients and the community.
* **Innovation:** Strive for innovative ways to improve the health outcomes of clients and community.
* **Collaboration:** Achieve optimal health outcomes for the Northern Indiana community through the involvement and participation of all stakeholders.

**Purpose of the CQM Program**

The purpose of HPI’s CQM program is to establish a coordinated approach in order to address quality assessment, evaluation, and process improvement for the care and services provided to all clients and community members. Improving programs and processes at HPI will result in improved health outcomes for clients and others living in Indiana.

## 2024 CQM Priorities:

**HPI’S 2024 CQM priorities align with Indiana’s 2023-2024 priorites and include:**

* **Viral Suppression Among People living with hiv In Indiana (PLWH)**
* **Prevention of New HIV and STD Infections**
* **STD Prevention through disease intervention**
* **The following is a list of potential service categories that HPI will focus on for the 2024 calendar year. We will be looking at these areas to find ways to increase utilization and improve results.**
	+ **DEFA (DIRECT EMERGENCY FINANCIAL ASSISTANCE)**
		- **We will look to decrease the utilization rate to increase self-sufficiency**
	+ **IDOH FUNDED HOUSING**
		- **We will look to increase the rate that clients go to permanent housing by increasing clients monthly income**
	+ **MEDICAL CASE MANAGEMENT**
		- **Increase viral suppression and retention in care**
	+ **NON-MEDICAL CASE MANAGEMENT**
		- **Increase viral suppression**
	+ **FOOD BANK**
		- **Increase viral suppression rate for Food Bank services and Medically Tailored Meals**
		- **Increase utilization rate**
		- **Increase food security**
	+ **PrEP**
		- **Increase retention in care**
	+ **VOA**
		- **Increase viral suppression rate**
	+ **HEPATITIS C**
		- **Increase treatment completion and testing in high risk groups**
	+ **MEDICAL TRANSPORTATION**
		- **Increase viral suppression**

**Infrastructure**

**Leadership**

HPI is a sub-recipient of the Ryan White HIV/AIDS Program (Part B grant), CDC Prevention Funds. HPI directly receives HRSA Ryan White Part C funds.

These efforts aim to identify and address the most significant needs of PLWH and to maximize coordination, integration, and effective linkages across the RW-funded services in Indiana.

With the support of the Executive Director, the following staff position will be responsible for overall leadership of the CQM Program:

* **Quality and Data Manager**-
	+ Responsible for preparing for and leading bi-monthly CQM committee meetings
	+ Participating in annual site visits
	+ With the support of HPI staff members on the CQM committee, QDM will introduce all quality related trainings and hold semiannual meetings
	+ Attend any quality related trainings
	+ Implement and compile data for all quality related projects
	+ Gather data for performance measures
	+ Update yearly CQM plan and work plan
	+ Submit quarterly project reports to IDOH

**Clinical Quality Management Committee**

The purpose of HPI’s CQM Committee is to serve as advisors to the CQM Program and to advise on performance measure evaluation and quality improvement activities across the services and prevention programs at the agency.

**Membership**

The following staff members and consumers will be consulted regarding performance measures and data collection and also serve as members of the CQM committee of the CQM Program:

1. Executive Director
2. Quality and Data Manager
3. Non-Medical Case Manager-Elkhart
4. Support Services Director
5. Prevention Staff
6. HPI-Austin Staff
7. Clinic Medical Director
8. Board Member
9. Consumer
10. Consumer-HPI Austin
11. Consumer-Part C Services
12. Stakeholder (Imani Unidad) representation
13. Stakeholder (Volunteers of America) representation
14. Community Volunteer

**Meetings**

The CQM Committee will meet bi-monthly, in January, March, May, July, September, and November 2024. If needed, the CQM Committee will also meet in December 2024 to finalize the 2024 Plan.

**COMMITTEE Responsibilties**

|  |
| --- |
| **Responsibilities** |
| 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 Agency |
| Advise on QI project recommendations |
| Act as a liaison between program areas and the CQM program |

**Stakeholder Involvement**

The following are key stakeholders of HPI’s CQM Program and their roles and responsibilities.

**Cultivate Food Rescue** provides frozen meals to qualifying clients

**Volunteers of America** provides mental health services helping to establish a “one stop shop” for clients

**Healthy U Pharmacy** is an in house pharmacy that will work with all clients’ insurance to fill prescriptions and deliver medications if necessary

**Imani Unidad** is a local social service agency that provides education in regards to primary and secondary prevention practices in order to reduce high-risk behaviors and increase self-image

**Dr. Won Chung**, who provides PrEP and HIV care to our Clients

**St. Joseph Health System and Memorial Hospital of Beacon Health System** are two main hospitals in our region. Many of the doctors serving agency clients belong to either health system

**Scott County EMS**, who we partner with for our Paramedicine Program

**Schneck Hospital**, who provides HIV care to our clients in Scott County

**CEAse of Scott County**, aims to prevent and reduce the incidence and prevalence of substance use addictions among youth and adults in Scott County

**Groups Recover Together**, is an addiction treatment center in Scottsburg

**Scott, Jackson, and Clark County Health Department**

**Indiana Legal Services, Center for the Homeless, South Bend Housing Authority, Indiana Health Center, Mosaic Health and Healing Arts, Indiana University South Bend, Olive Street Clinic, Bowen Center, Oaklawn, Scott County YMCA, Food 4 R Souls, Wooded Glen are additional service providers in the area that assist agency clients.**

As HPI moves through the cyclical process of quality management and improvement, stakeholders will be consulted on areas of improvement and potential collaborative strategies for improvement. HPI will communicate to stakeholders bi-monthly via the Constant Contact email program to update them on agency information as well as quality improvement.

**Consumer Involvement**

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

* Consumers participate in yearly client surveys- this will serve as an additional mechanism to solicit ideas/solutions/suggestions for the CQM Program (these surveys will be administered October-November of 2024)
* Consumer presence on Board of Directors
* Quarterly consumer forums with the Executive Director to obtain consumer feedback
* The CQM committee will also be holding focus groups that require consumer involvement on an as needed basis as pertains to ongoing CQM projects

# 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. All measures are prioritized based on relevance, measurability, accuracy, and improvability. RWHAP will utilize the HIV/AIDs Bureau (HAB) measures for all RW funded categories. Non-RWHAP funded program measures are selected based on the priorities of those programs and their funders. 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.**

**Evaluation**

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

* **The Plan-Do-Study-Act tool to evaluate projects and confirm that the plan is sufficient**
* **The CQM Committee will also hold a group discussion to evaluate the work plan to assess the efficacy of the CQM program. This will be completed annually in November by the CQM Team**
* **Data trends**
* **Quarterly QI reporting form to IDOH**

**Updating the CQM Plan**

Annually in September, HPI’S CQM committee will discuss the CQM Plan and any needed revisions, based on the timeline and content of the IDOH CQM Plan that will be released annually. The Quality and Data Manager will then create a draft of the upcoming year’s CQM Plan and bring it back to the full committee for review and revisions.

**Capacity Building**

HPI will seek to build a culture of quality by integrating Quality Improvement trainings into each staffed position. All existing staff members have completed the assigned Quality Academy tutorials. The Quality and Data Manager will meet with each new staff member to introduce Quality Management, as well as monitor the employees’ progress in completing the Quality Academy Trainings. Upon completion of the trainings, the staff member will present all staff certificates to QDM. Staff will also be heavily involved in implementing all Quality Improvement projects that are initiated by CQM Committee. Certain staff members will also be the sole individual collecting data for various CQM projects.

**Communication and Information Sharing**

Semiannually, in June and December, the QDM will hold an all-staff meeting to provide updates regarding quality projects. QDM will also integrate games that teach quality improvement into staff meetings twice per year in March and September. We will also communicate any QI updates with consumers via the Harness text messaging system on an as needed basis.To share our progress with stakeholders, a “QI corner” will be added to the bi-monthly Constant Contact email.QDM will also relay Viral Suppression finding to the COC committee quarterly.

**Appendix**

**Performance Measures-Part B**

| **Service****Category** | **Performance Measure** | **Operational Definition** | **Disparity Evaluation** | **Measurement Period, Reporting Frequency, and Target** | **Data Source** |
| --- | --- | --- | --- | --- | --- |
| Non-medical Case Management  | HIV Viral Load Suppression | **Description:** Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year. **Numerator:** Number of patients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year**Denominator**: The number of patients, regardless of age, with a diagnosis of HIV who had at least one non-medical case management visit in the measurement year**Exclusions**: Patients diagnosed with HIV (new intakes) and patients who died or moved out of state during the measurement year. | * 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-calendar**Reporting Frequency**: Quarterly**Site Target: 93%****Site Baseline: 88.8%** | **RWISE & CAREWare** |
| Non-medical Case Management-Enrollment Specialist   | HIV Viral Load Suppression | **Description:** Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year who received a NMCM-ES visit during the measurement period.**Numerator:**  Number of patients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year**Denominator:** Number of unduplicated clients who received a NMCM-ES visit during the measurement period.**Exclusions:** Patients who died or moved out of state during measurement period.  | * Medicare
* Medicaid
* Private
* Ryan White
	+ ADAP
	+ HIAP
 | **Measurement Period**: 12 months-calendar**Reporting Frequency**: Quarterly**Site Target**: **93%****Site Baseline: 89.9%** | **RWISE & CAREWare** |
| Medical Case Management\*  | HIV Viral Load Suppression | **Description:** Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year. **Numerator:** Number of patients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year**Denominator**: The number of patients referred for medical case management services during the measurement year.**Exclusions:**PrEP patients, patients diagnosed with HIV (new intakes), and patients who died or moved out of state during the measurement year. | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period:** 12 months-Calendar**Reporting Frequency:** Quarterly**Site Target: 95%****Site Baseline: 91.3%** | **RWISE & CAREWare** |
| Medical Case Management\* | Retention in Care | **Description:** Percentage of clients who were referred for MCM services, that had more than one MCM visit during the measurement period **Numerator:** The number of clients in the denominator who had more than one medical visit in the measurement year.**Denominator**: The number of clients who were referred for MCM services**Exclusions:** None | * HIV diagnosis vs. AIDS diagnosis
* Race/Ethnicity:
	+ White
	+ African American/Black
* Hispanic
 | **Measurement Period**: 12 months-Calendar**Reporting Frequency**: Yearly**Site Target**: 80%**Site Baseline: 74.3%** | **CAREWare** |
| Food Bank | HIV Viral Load Suppression | **Description:** Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year. **Numerator:** Number of patients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year**Denominator**: The number of patients, regardless of age, with a diagnosis of HIV who had at least one food bank service in the measurement year**Exclusions**: Patients diagnosed with HIV (new intakes) and patients who died or moved out of state during the measurement year. | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period**: 12 months (July 1-June 30)**Reporting Frequency**: Quarterly**Site Target: 94%****Site Baseline: 92.3%** | **RWISE & CAREWare** |
| Food Bank-Medically Tailored Meals | HIV Viral Suppression | **Description:** Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year. **Numerator:** Number of patients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year**Denominator**: The number of patients, regardless of age, with a diagnosis of HIV who had at least one Medically Tailored Meal service in the measurement year**Exclusions**: Patients diagnosed with HIV (new intakes) and patients who died or moved out of state during the measurement year. | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period**: 12 months (July 1-June 30)**Reporting Frequency**: Quarterly**Site Target: 90%****Site Baseline: 86.9%** | **RWISE & CAREWare** |
| Food Bank | Utilization Rate | **Description:** Percentage of consumers who received nutritional assistance from the internal food pantry during the measurement year. **Numerator:**  The total number of unduplicated clients served nutritional assistance during the measurement year **Denominator:** The total number of clients served during the measurement year.**Exclusions:** None | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period**: 12 months (July 1-June 30)**Reporting Frequency**: Yearly**Site Target: 35%****Site Baseline: 37.5%** | **Internal Pantry Tracker & CAREWare** |
| Food Bank | Food Insecurity | **Description:** Percentage of consumers who receive nutritional assistance that identify as food insecure**Numerator:** The total number of unduplicated clients who answer “always” or “sometimes” to food security questions**Denominator:** The total number of consumers served nutritional assistance during the measurement year**Exclusions:** None | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period**: 12 months-calendar year**Reporting Frequency**: Yearly**Site Target: 50%****Site Baseline: 13.9%** | **Annual Client Survey Data & CAREWare** |
| ISDH Housing | HIV Viral Suppression | **Description:** Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year. **Numerator:** Number of patients (who access ISDH housing) in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year**Denominator**: The number of patients, regardless of age, with a diagnosis of HIV who accessed ISDH housing during the measurement year.**Exclusions**: Patients diagnosed with HIV (new intakes) and patients who died or moved out of state during the measurement year. | * 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 (October 1, 2021-September 30, 2022) **Reporting Frequency**:Quarterly on M3**Site Target: 87%****Site Baseline: 82.4%** | **RWISE & CAREWare** |
| Direct Emergency Financial Assistance (DEFA) | HIV Viral Load Suppression | **Description:**  Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year.**Numerator:** Number of patients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year**Denominator:** The number of unduplicated clients who have received financial assistance within the measurement year.**Exclusions**: Patients diagnosed with HIV (new intakes) and patients who died or moved out of state during the measurement year. | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period:** 12 months (July 1- June 30)**Reporting Frequency:** Quarterly**Site Target: 93%****Site Baseline: 90.6%****(UPDATED FOR 2025 PLAN YEAR)** | **RWISE, CAREWare, & Internal DEFA Tracker** |
| Utilization Rate  | **Description:** Percentage of clients who received financial assistance during the measurement year**Numerator:**  The number of unduplicated clients who have accessed financial assistance during the measurement year**Denominator:**  The total number of times that clients have accessed financial assistance during the measurement year**Exclusions:** None | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period:**12 months (July 1-June 30)**Reporting Frequency:** Yearly**Site Target: 50%****Site Baseline: 81.1%****(UPDATED FOR 2025 PLAN YEAR)** | **Internal DEFA Tracker, RWISE** |
| PrEP | Retention in Care | **Description:**  Percentage of patients referred to services during the measurement year who were retained in care**Numerator:** Number of individuals who attended at least two medical appointments during the measurement year **Denominator:**  Number of clients who were referred to the PrEP navigator**Exclusions**: None | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period:** 12 months-calendar**Reporting Frequency:** Quarterly**Site Target: 15%****Site Baseline: 13.1%** | **Internal PrEP tracker, Aprirm** |
| PrEP\* | Retention in Care | **Description:**  Percentage of patients referred to services during the measurement year who were retained in care**Numerator:** Number of individuals who attended at least two medical appointments during the measurement year **Denominator:**  Number of clients who were referred to the PrEP navigator**Exclusions**: None | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period:** 12 months-calendar**Reporting Frequency:** Quarterly**Site Target: 94%****Site Baseline: 92.9%** | **Internal PrEP tracker, Aprirm** |
| VOA | HIV Viral Load Suppression | **Description:**  Percentage of patients referred to services during the measurement year who were virally suppressed**Numerator:** Number of patients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year **Denominator:**  The number of unduplicated clients who have received VOA services within the measurement year.**Exclusions**: Clients who left VOA services during measurement year | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period:** 12 months-calendar**Reporting Frequency:** Yearly on M12**Site Target: 87%** **Site Baseline: 77.8%** | **VOA Client Tracker, CAREWare, RWISE**  |
| Hepatitis C | Treatment Completion | **Description:** The number of clients that are referred and successfully complete Hepatitis C treatment**Numerator:** The number of clients who completed treatment during the measurement year**Denominator**: The number of clients who were referred during the measurement year**Exclusions**: Patients who did not complete treatment | * 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-Calendar**Reporting Frequency**: Quarterly**Site Target: 65%****Site Baseline: N/A** | **Excel, Aphirm** |
| Hepatitis C\* | Treatment Completion | **Description:** The number of clients that are referred and successfully complete Hepatitis C treatment**Numerator:** The number of clients who completed treatment during the measurement year**Denominator**: The number of clients who were referred during the measurement year**Exclusions**: Patients who did not complete treatment | * 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-Calendar**Reporting Frequency**: Quarterly**Site Target: 65%****Site Baseline: N/A** | **Excel, Aphirm** |
| Hepatitis C Testing\* | Testing in High Risk Groups | **Description:** Tracking the number of those tested that have the following Risk Factors: Male to Male Sexual Contact (MSM) or Injection Drug Use**Numerator:** Number of HIV tests performed on high-risk individuals during the measurement year**Denominator:** Number of HIV tests performed during the measurement year | * Risk Factor:
	+ MSM
	+ AA
	+ White
	+ Hispanic
	+ IDU
 | **Measurement Period**: 12 months-Calendar**Reporting Frequency**: Quarterly**Site Target: 65%****Site Baseline: N/A** | **Aphirm** |
| Medical Transportation | HIV Viral Load Suppression | **Description:** Percentage of clients with a diagnosis of HIV with an HIV viral load less than 200 copies/ml at last HIV vial load test during the measurement year**Numerator:** Number of clients in the denominator with an HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year**Denominator**: The total number of clients that had at least one medical transportation visit during the measurement year**Exclusions**: Clients that did not have an HIV viral load test, died, or moved away during the measurement year | * 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-Calendar**Reporting Frequency**: Quarterly**Site Target: 93%****Site Baseline**: **90.5%** | **RWISE & CAREWare** |
| Medical Transportation\* | HIV Viral Load Suppression | **Description:** Percentage of clients with a diagnosis of HIV with an HIV viral load less than 200 copies/ml at last HIV vial load test during the measurement year**Numerator:** Number of clients in the denominator with an HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year**Denominator**: The total number of clients that had at least one medical transportation visit during the measurement year**Exclusions**: Clients that did not have an HIV viral load test, died, or moved away during the measurement year | * 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-Calendar**Reporting Frequency**: Quarterly**Site Target: 97%****Site Baseline**: **95%** | **RWISE & CAREWare** |

\*Asterisked service categories are dual Part B measures for HPI and HPI-Austin

**Performance Measures-Part C**

| **Service****Category** | **Performance Measure** | **Operational Definition** | **Disparity Evaluation** | **Measurement Period, Reporting Frequency, and Target** | **Data Source** |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| EIS | HIV Testing and Counseling | **Description:** Clients will receive targeted testing**Activities:** Health fairs, large-scale events, Kiosk testing, outreach towards high-risk populations, drop-off testing, integrated testing**Exclusions**: None | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period**: 12 months-calendar**Reporting Frequency**:Yearly **Site Target: 500 clients****Site Baseline: N/A** | **Aphirm** |
| EIS  | HIV Testing and Counseling  | **Description:** Clients will have a confirmatory positive HIV test**Activities**: Confirmatory tests (lab-based blood draw) or positive rapid test**Exclusions:** Negative test results | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period**: 12 months-calendar**Reporting Frequency**: Yearly**Site Target**: **3****Site Baseline**: **N/A** | **Aphirm** |
| **Service****Category** | **Performance Measure** | **Operational Definition** | **Disparity Evaluation** | **Measurement Period, Reporting Frequency, and Target** | **Data Source** |
| Core Medical & EIS | Linkage to Care | **Description:** Newly diagnosed individuals will enroll in care within one month of HIV diagnosis**Activities**: Referrals to medical provider and non-medical case manager**Exclusions**: Clients who have been diagnosed for > 1 month | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period**: 12 months-calendar**Reporting Frequency**:Yearly **Site Target: 30 clients****Site Baseline: N/A** | **CAREWare** |
| Core Medical | Retention in Care | **Description:** Clients will receive mental health services **Activities:** New diagnosis referrals, assistance with partner notification, emotional support**Exclusions:** None | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period**: 12 months-calendar**Reporting Frequency**: Yearly**Site Target**: **40 clients****Site Baseline**: **N/A** | **CAREWare** |
| **Service****Category** | **Performance Measure** | **Operational Definition** | **Disparity Evaluation** | **Measurement Period, Reporting Frequency, and Target** | **Data Source** |
| Core Medical | Retention in Care  | **Description:** Clients will receive medical case management**Activities:** Referrals to Medical Case Manager, Daily client check-ins, coordination of medical care**Exclusions**: None | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period**: 12 months-calendar**Reporting Frequency**:Yearly **Site Target: 40 clients****Site Baseline: N/A** | **CAREWare** |
| Core Medical  | ART and Viral Suppression  | **Description:** Clients will receive ART**Activities:** Clinic referrals and medication adherence strategies | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period**: 12 months-calendar**Reporting Frequency**: Yearly**Site Target**: **100 clients****Site Baseline**: **N/A** | **CAREWare/****Athena** |
| Core Medical  | ART and Viral Suppression  | **Description:** Clients will be virally suppressed **Activities**: Clinic referrals and medication adherence strategies | * Race/Ethnicity:
	+ White
	+ African American/Black
	+ Hispanic
* Gender:
	+ Women
	+ Transgender
	+ MTF
	+ FTM
* Age:
	+ 13-24
	+ 25-34
	+ 35-44
	+ 45-54
	+ 55-64
	+ 65+
 | **Measurement Period**: 12 months-calendar**Reporting Frequency**: Yearly**Site Target**: **91 clients****Site Baseline**: **N/A** | **CAREWare/****Athena** |

The Health Plus Indiana CQM Plan has been approved by the CQM Team and HPI leadership. The plan is effective from 1/1/2024 until 12/31/2024.

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**Leeah Hopper, Executive Director Valerie Risselmann, Clinical Quality Manager**