

STATE OF NEVADA – OFFICE OF HIV RYAN WHITE PART B AND
AIDS DRUG ASSISTANCE PROGRAM CLINICAL QUALITY
MANAGEMENT PLAN

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APPROVAL AND ADOPTION

This Clinical Quality Management Plan is approved and adopted by the Nevada Office of HIV for the Ryan White Part B and AIDS Drug Assistance Program for Grant Year April 1, 2026– March 31, 2027.

This plan reflects compliance with HRSA HAB Policy Clarification notice 15-02 and establishes the statewide framework for Clinical Quality Management activities.

ACRONYMS

The following acronyms are used throughout this document:

- Clinical Quality Management Plan (CQMP)
- Nevada Office of HIV (OOH)
- Ryan White Part B (RWPB)
- AIDS Drug Assistance Program (ADAP) / Nevada Medication Assistance Program (NMAP)
- Health Resources and Services Administration (HRSA)
- HIV/AIDS Bureau (HAB)
- Policy Clarification Notice (PCN)
- Ryan White Services Report (RSR)

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SECTION 1: GENERAL INFORMATION AND AUTHORITY

1.1 Purpose

The Nevada Office of HIV administers the Ryan White Part B and AIDS Drug Assistance Program (NMAP/ADAP) and maintains responsibility for compliance with all applicable federal requirements, including HRSA HIV/AIDS Bureau Policy Clarification Notice 15-02 (Clinical Quality Management).

This Clinical Quality Management (CQM) Plan establishes the statewide framework for the development, implementation, oversight, and evaluation of CQM activities. The purpose of this plan is to ensure that HIV services funded through the Ryan White Part B and NMAP/ADAP programs are consistent with current U.S. Department of Health and Human Services guidelines, responsive to identified community needs, and supported by measurable quality improvement efforts.

This document defines the structure, expectations, and accountability mechanisms that guide clinical quality management activities across the State of Nevada.

1.2 Scope and Applicability

This CQM Plan applies to:

- The Nevada Office of HIV
- All funded Ryan White Part B subrecipients
- All funded NMAP/ADAP contractors and participating providers

All entities receiving Part B or NMAP/ADAP funds are required to participate in the statewide CQM Program as outlined in this plan.

This document governs:

- Quality infrastructure
- Performance measurement processes
- Quality improvement activities
- Integration of CQM with monitoring functions
- Evaluation of CQM program effectiveness

Operational standards contained within this plan established by the Nevada Office of HIV to support the integrity and effectiveness of the CQM Program. These standards complement federal requirements and align with contractual and programmatic guidance.

1.3 Alignment with Federal Requirements

This CQM Plan aligns with HRSA HAB Policy Clarification Notice 15-02, which requires recipients to establish and maintain a Clinical Quality Management Program that includes:

- Appropriate infrastructure
- Ongoing performance measurement
- Implementation of quality improvement activities
- Use of data to inform improvement efforts
- Evaluation of CQM effectiveness

The Nevada Office of HIV retains responsibility for ensuring that the statewide CQM Program meets these requirements and for working directly with subrecipients to provide direction, guidance, and oversight.

1.4 Authority and Accountability

The Nevada Office of HIV holds final authority and accountability for the Clinical Quality Management Program.

The CQM Coordinator is responsible for:

- Developing and maintaining the CQM Plan
- Facilitating the CQM Committee
- Overseeing performance measurement activities
- Coordinating quality improvement initiatives
- Integrating CQM with monitoring processes
- Ensuring alignment with federal and state requirements

Subrecipients are responsible for participating in statewide CQM activities, maintaining data integrity, engaging in quality improvement efforts, and addressing identified performance or compliance issues within established timelines.

1.5 Plan Review and Revision

This CQM Plan is reviewed annually and updated as necessary to reflect changes in federal guidance, statewide priorities, or program structure.

Structural revisions are made only when required. Annual benchmarks, performance measures, timelines, and work plans are maintained in appendices to minimize substantive revisions to the core framework.

SECTION 2: QUALITY STATEMENT

The Nevada Ryan White Part B and NMAP/ADAP Clinical Quality Management Program is committed to ensuring equitable access to high-quality HIV care and support services that lead to sustained viral suppression, improved health outcomes, and effective use of public resources.

The program advances quality through structured performance measurement, continuous quality improvement, and coordinated monitoring activities designed to strengthen service delivery systems and reduce variation across providers.

Through data-informed decision-making, stakeholder engagement, and clear accountability standards, the Nevada Office of HIV works to ensure that funded services are consistent with current federal treatment guidelines and responsive to the needs of people with HIV throughout the State of Nevada.

SECTION 3: ANNUAL QUALITY GOALS

Each grant year, the Nevada Office of HIV establishes a limited number of Annual Quality Goals to guide statewide Clinical Quality Management activities. Goals are informed by performance data, monitoring findings, stakeholder input, and identified system priorities.

Annual Quality Goals are designed to:

- Strengthen CQM infrastructure
- Improve performance measurement reliability

- Advance quality improvement efforts
- Address identified service gaps or disparities
- Promote data integrity and accountability

Goals are measurable, time-bound, and aligned with federal requirements under HRSA HAB Policy Clarification Notice 15-02.

Specific annual benchmarks, performance targets, and timelines are maintained in Appendix A.

The CQM Committee reviews progress toward Annual Quality Goals at minimum quarterly. Adjustments to activities may be made based on performance trends, monitoring findings, or emerging program needs.

Achievement of Annual Quality Goals is evaluated at the conclusion of each grant year and informs planning for the subsequent cycle.

All Annual Quality Goals are expected to follow a SMART framework, ensuring goals are Specific, Measurable, Achievable, Relevant, and Time-bound to support clear tracking, accountability, and performance improvement.

SECTION 4: QUALITY INFRASTRUCTURE

4.1 Leadership and Accountability

Appropriate leadership and defined accountability are foundational to an effective Clinical Quality Management Program.

The Nevada Office of HIV retains final authority and responsibility for ensuring that the Ryan White Part B and NMAP/ADAP Clinical Quality Management Program complies with HRSA HAB Policy Clarification Notice 15-02 and supports improved patient outcomes.

Program leadership:

- Endorses and supports CQM activities
- Ensures adequate resources are allocated for CQM functions
- Reviews performance data and program progress
- Provides oversight and quality improvement priorities

The CQM Coordinator is responsible for operationalizing the CQM framework and ensuring statewide implementation of CQM activities in alignment with this plan.

4.2 CQM Committee Structure and Function

The Clinical Quality Management Committee serves as the formal body responsible for guiding statewide CQM activities.

The CQM Committee:

- Meets at minimum quarterly
- Reviews performance measure data
- Identifies improvement priorities
- Monitors progress toward Annual Quality Goals
- Reviews quality improvement project updates
- Provides structured feedback regarding system performance

Committee membership includes representation from the Nevada Office of HIV and funded subrecipients. Additional stakeholders may participate as appropriate.

Meeting agendas, attendance, and action items are documented and maintained as part of the CQM program record.

4.3 Dedicated Staffing and Resources

The Nevada Office of HIV allocates dedicated staffing and resources to support the Clinical Quality Management Program.

The CQM Coordinator is responsible for:

- Development and maintenance of the CQM Plan
- Facilitation of CQM Committee meetings
- Coordination of performance measurement activities
- Data analysis and reporting
- Oversight of quality improvement activities
- Integration of CQM activities with monitoring functions

CQM-related costs are maintained within applicable statutory limits for Ryan White Part B programs.

4.4 Roles and Responsibilities

Roles and responsibilities for CQM activities are clearly defined to ensure accountability across all participating entities.

State Office of HIV responsibilities include:

- Establish statewide CQM priorities
- Providing guidance and oversight to subrecipients
- Reviewing performance data
- Coordinating technical assistance
- Integrating monitoring findings with CQM activities

Subrecipient responsibilities include:

- Participating in CQM Committee meetings
- Reviewing assigned performance measures
- Implementing quality improvement activities
- Maintaining data integrity
- Addressing identified performance or compliance issues

A detailed roles and Responsibilities table is maintained in Appendix B.

4.5 Stakeholder and People with HIV Involvement

The Nevada Office of HIV incorporates stakeholder and consumer input into CQM activities to ensure services reflect the needs of people with HIV.

Stakeholder involvement may include:

- Subrecipient leadership participation
- Consumer advisory input
- Feedback mechanisms
- Community engagement activities

Stakeholder input is considered when establishing annual goals, performance priorities, and quality improvement initiatives.

4.6 Evaluation of the CQM Program

The Nevada Office of HIV conducts an annual evaluation of the Clinical Quality Management Program to assess effectiveness, progress toward goals, and overall program impact.

Evaluation includes review of:

- Achievement of Annual Quality Goals
- Performance measurement trends
- Quality improvement outcomes
- Stakeholder engagement
- Integration between CQM and monitoring functions

Findings from the evaluation inform adjustments to priorities, infrastructure, and improvement strategies for the subsequent grant year.

SECTION 5: PERFORMANCE MEASUREMENT FRAMEWORK

5.1 Purpose

Performance measurement is the structured process of collecting, analyzing, and reporting data related to patient care, health outcomes, and service delivery. Performance measurement activities are designed to assess the quality and effectiveness of Ryan White Part B and NMAP/ADAP-funded services and to inform quality improvement efforts.

5.2 Measure Selection

The Nevada Office of HIV selects performance measures in alignment with HRSA HAB Policy Clarification Notice 15-02 and applicable federal guidelines.

Performance measure selection is informed by:

- Utilization of funded service categories
- Local HIV epidemiology
- Identified community needs
- Federal HIV performance measures
- National HIV/AIDS strategy indicators

In accordance with federal guidance:

- For service categories in which $\geq 50\%$ of eligible clients receive at least one unit of service, at least two performance measures are identified.
- For service categories in which $>15\%$ and $<50\%$ of eligible clients receive at least one unit of service, at least one performance measure is identified.
- For service categories in which $\leq 15\%$ of eligible clients receive at least one unit of service, performance measures are not required.

The complete performance measure portfolio is maintained in Appendix C.

5.3 Data Collection and Review

Performance measure data are collected and reviewed at minimum quarterly.

The performance measurement process includes:

- Data extraction from CAREWare and other designated systems
- Validation of numerator and denominator calculations
- Review of performance trends over time
- Identification of areas below established benchmarks

Subrecipients are expected to review assigned performance data and participate in structured discussions regarding findings and improvement opportunities.

Additional guidance, tools, and reporting resources are available to subrecipients on the Nevada Office of HIV website for ongoing reference and support.

5.4 Data Analysis and Stratification

Performance data may be stratified, when feasible, to identify potential disparities in outcomes across populations or service providers.

Analysis may include:

- Age
- Gender
- Race and Ethnicity
- Geographic region
- Service category

Findings are used to inform quality improvement priorities and targeted technical assistance.

5.5 Use of Performance Data

Performance measurement data are used to:

- Inform Annual Quality Goals
- Identify areas requiring quality improvement
- Guide technical assistance
- Support monitoring integration
- Evaluate program effectiveness

Performance measurement activities are continuous and integrated within the broader CQM framework.

SECTION 6: QUALITY IMPROVEMENT FRAMEWORK

6.1 Purpose

Quality improvement (QI) activities are systemic, data-informed efforts designed to improve patient care, health outcomes, and service delivery processes within Ryan White Part B and NMAP/ADAP programs.

Quality improvement activities are implemented in response to performance measurement findings and identified system priorities. QI activities are continuous and integrated within broader Clinical Quality management framework.

6.2 Defined Methodology

The Nevada Office of HIV utilizes the Plan-Do-Study-Act (PDSA) methodology as the structured approach for quality improvement activities. Lean-informed process improvement principles may be incorporated where appropriate. The CQM Program utilizes a Lean-informed process improvement approach, focused on identifying variation, improving workflow efficiency, and strengthening system-level performance.

All QI activities must:

- Be clearly defined
- Identify a measurable aim
- Include baseline data
- Implement an intervention or change strategy
- Measure results
- Document findings

QI projects must be implemented in an organized and systematic manner to determine whether implemented changes result in measurable improvement.

6.3 Selection of Quality Improvement Priorities

Quality improvement priorities are informed by:

- Performance measurement data
- Identified service gaps
- Monitoring findings
- Stakeholder input
- Emerging statewide needs

In addition, the Nevada Office of HIV utilizes structured statewide assessments, including subrecipient SWOT analyses and Organizational Assessments, to identify system-level gaps impacting performance, consistency, and client outcomes.

Findings from these assessments are synthesized to identify statewide priority focus areas. These priorities are used to guide:

- Quality improvement activities
- Technical assistance efforts
- Monitoring and oversight activities

Statewide priority areas and alignment strategies are maintained in the CQM Plan appendices, including Appendix H: Subrecipient SWOT Analysis Roll-Up and Statewide Quality Improvement Alignment, and are updated as needed to reflect current program needs.

In alignment with federal requirements, quality improvement activities are conducted within funded service categories. The Nevada Office of HIV supports a structured approach that may include multiple focused improvement efforts throughout the grant year rather than a single annual project.

Subrecipients are expected to implement targeted, data-informed improvement cycles that align with identified performance gaps and statewide priority areas. Activities that do not demonstrate alignment may be subject to review and require modification through monitoring or technical assistance processes.

Quality improvement activities are reviewed through the CQM Committee and aligned with Annual Quality Goals.

6.4 Documentation and Reporting

All quality improvement activities must be documented.

Documentation includes:

- Project aim statement
- Baseline data
- Description of intervention
- Data collected during implementation
- Results and conclusions
- Lessons learned

Subrecipients are required to report QI activities according to timelines established in the Work Plan and Appendices.

6.5 Subrecipient Engagement and Capacity Building

The Nevada Office of HIV provides guidance and support to subrecipients to ensure capacity to participate in quality improvement activities.

Support may include:

- Technical assistance
- Coaching
- Training opportunities
- Structured feedback on QI projects

Subrecipients are expected to actively engage in QI activities and incorporate findings into operational practices.

6.6 Relationship Between QI and Compliance

Quality improvement activities are designed to improve systems and processes.

Quality improvement does not replace the requirement to resolve identified compliance deficiencies within established timelines.

Monitoring findings requiring corrective action must be addressed independently of ongoing QI activities.

SECTION 7: OPERATIONAL STANDARDS

Operational standards are established by the Nevada Office of HIV to support the integrity, reliability, and effectiveness of the Clinical Quality Management Program. These standards complement federal requirements and align with contractual and programmatic guidance.

Operational standards provide clarity regarding minimum expectations necessary to support performance measurement accuracy, quality improvement activities, and statewide program accountability.

7.1 Data Integrity and Entry Standards

Accurate and timely data entry is foundational to performance measurement and quality improvement activities.

Subrecipients must enter service and client data into CAREWare in accordance with established contract and State Office of HIV guidance.

Data must be:

- Timely in relation to service delivery
- Complete and accurate
- Supported by documentation maintained in the client record

The Nevada Office of HIV conducts routine data validation reviews to ensure alignment between documentation and reported data.

Identified patterns of delayed entry, incomplete documentation, or discrepancies may result in targeted technical assistance or monitoring follow-up.

Data entry is expected to occur as close to real-time as possible. At minimum, all required data elements must be entered within 24 hours of service delivery. Same-day entry is strongly encouraged to support data accuracy, timely reporting, and effective program monitoring.

Failure to meet data timeliness expectations may be addressed through routine monitoring, technical assistance, or escalation processes as outlined in this plan.

7.2 Assessment and Service Documentation Standards

Assessments and service documentation must support continuity of care, appropriate service planning, and accurate performance reporting.

Subrecipients must ensure:

- Initial and required reassessments are completed within established program timelines
- Documentation supports service provision and reported data
- Eligibility documentation remains current and verifiable

Assessment documentation standards may be reviewed during routine performance monitoring and file review activities.

7.3 Participation and Reporting Expectations

Participation in statewide CQM activities is required for all funded subrecipients.

Subrecipients are required to actively participate in the RWPB and/or NMAP/ADAP Clinical Quality Management (CQM) Committee and designate at least one representative to attend each meeting unless otherwise specified.

Subrecipients are expected to support client engagement in quality activities, including participation in client satisfaction surveys, focus groups, and needs assessments to inform service delivery improvements.

Subrecipients must ensure services are delivered in accordance with HRSA HAB requirements, including applicable National Monitoring Standards.

Subrecipients are required to provide CQM-related updates through Quarterly Reports and the Final Year-End Report. Updates must include, at minimum, performance measure data,

quality improvement activities, and any identified challenges or barriers impacting service delivery or outcomes.

Failure to meet participation and reporting expectations may result in escalation as outlined in Section 8.

7.4 Integration with CQM Framework

Operational standards support the broader Clinical Quality management framework and are designed to promote consistency across subrecipients.

These standards do not replace federal requirements, contractual obligations, or monitoring expectations but function in coordination with those processes to strengthen overall program integrity.

SECTION 8: MONITORING AND ESCALATION FRAMEWORK

8.1 Relationship Between Monitoring and CQM

Grant monitoring and compliance oversight are administrative functions required to ensure adherence to federal and contractual requirements. Monitoring activities inform the Clinical Quality management Program but are distinct from CQM activities.

Monitoring findings, chart reviews, and compliance assessments may identify areas requiring corrective action. These findings may also inform quality improvement priorities when appropriate.

The Nevada Office of HIV integrates monitoring results with performance measurement and quality improvement activities to strengthen overall program integrity.

8.2 Structured Escalation Framework

To promote accountability and consistency, the Nevada Office of HIV utilizes a structured escalation approach when performance concerns or compliance deficiencies are identified.

Escalation may include the following levels:

Level 1: Routine Review

Triggered when:

- Minor data quality issues are identified
- Isolated missed performance targets
- Inconsistent documentation or reporting practices
- Early signs of performance variation

Response:

- Informal feedback
- Routine monitoring
- Technical assistance as needed

Level 2: Performance Notification

Triggered when:

- Repeated failure to meet performance targets over multiple reporting periods
- Ongoing data quality or timeliness issues

- Lack of response to prior technical assistance
- Identified gaps in required processes (e.g., assessments, documentation)

Response:

- Formal written notification
- Targeted technical assistance
- Defined expectations for corrective action

Level 3: Corrective Action Plan

Triggered when:

- Sustained underperformance despite prior intervention
- Failure to implement required corrective actions
- Significant compliance concerns
- Continued data integrity or reporting failures

Response:

- Formal CAP issued
- Required action plan with timelines and deliverables
- Increased monitoring and follow-up

Level 4: Enforcement Action

Triggered when:

- Failure to comply with CAP requirements
- Ongoing non-compliance or program risk
- Inability or unwillingness to meet program expectations

Response:

- Escalation to leadership
- Potential funding or contractual actions
- Additional enforcement as applicable

8.3 Distinction Between Quality Improvement and Corrective Action

Quality improvement activities are designed to improve systems and processes using structured methodology.

Corrective action plans address compliance deficiencies and must be resolved within established timelines.

Quality improvement activities do not replace the requirement to correct compliance findings.

SECTION 9: RISK MANAGEMENT

The CQM Program incorporates a structured approach to identifying, monitoring, and responding to risks that may impact program performance, service delivery, or compliance.

9.1 Risk Identification

Risks may include, but are not limited to:

- Staffing turnover or capacity limitations
- Data system issues or outages (e.g., CAREWare, RWISE)
- Delays in data entry or reporting
- Compliance concerns or monitoring findings
- Service delivery disruptions

9.2 Risk Reporting

Subrecipients are expected to communicate identified risks to the recipient in a timely manner, particularly when those risks may impact performance outcomes, data integrity, or client care.

For the purposes of this plan, “timely” is defined as:

- Within 24 hours for urgent or high-impact risks (e.g., system outages, major staffing disruptions, or issues affecting client care or access to services)
- Within 3–5 business days for non-urgent risks that may impact performance, reporting, or compliance if not addressed

9.3 Risk Response

Identified risks will be addressed through existing CQM structures, including:

- Technical assistance
- Routine monitoring and data review
- Escalation through the Structured Escalation Framework
- Corrective Action Plans, if necessary

9.4 Integration with CQM Activities

Risk management is integrated into ongoing CQM activities, including performance measurement, site visits, and data review processes, to ensure early identification and proactive response.

SECTION 10: EVALUATION OF THE CQM PROGRAM

10.1 Purpose

The Nevada Office of HIV conducts annual evaluation of the Clinical Quality Management Program to assess its effectiveness, sustainability, and impact on patient care and health outcomes.

Evaluation ensures that CQM activities are implemented as outlined in this plan and that program efforts contribute to measurable improvement.

10.2 Components of Evaluation

The annual CQM evaluation includes review of:

- Achievement of Annual Quality Goals
- Performance measurement trends and benchmark attainment
- Quality improvement project outcomes
- Implementation of action items and deliverables
- Stakeholder and subrecipient engagement
- Integration between CQM activities and monitoring functions
- Timeliness of planned activities outlined in the Work Plan

Evaluation focuses on both outcomes and process reliability.

10.3 Evaluation Process

Evaluation activities may include:

- Review of quarterly performance data summaries
- Review of QI project documentation
- Assessment of committee participation and engagement
- Leadership review of CQM progress reports
- Identification of barriers to implementation

Findings are documented and used to inform planning for the subsequent grant year.

10.4 Continuous Refinement

If evaluation identifies areas where CQM activities have not produced the intended impact, the Nevada Office of HIV will:

- Adjust performance measurement priorities
- Refine quality improvement strategies
- Modify infrastructure components as appropriate
- Update Annual Quality Goals

Evaluation is conducted in a manner proportionate to the size and scope of the program and is designed to support continuous improvement rather than create administrative burden.

SECTION 11: WORK PLAN

11.1 Purpose

The Clinical Quality Management Work Plan operationalizes the goals and priorities outlined in this CQM plan. The Work Plan establishes structured activities, timelines, and accountability to ensure implementation of CQM infrastructure, performance measurement, and quality improvement efforts.

The Work Plan functions as the implementation roadmap for the grant year.

11.2 Structure

The Work Plan is maintained in Appendix D and includes, at minimum:

- Objective or priority area
- Key activities and milestones
- Responsible party
- Timeline or deadline
- Expected outcome or deliverable

Activities within the Work Plan align with Annual Quality Goals and reflect required components of the CQM Program.

11.3 Review and Accountability

The Work Plan is review at minimum quarterly through established CQM reporting mechanisms.

Progress toward activities and milestones is documented. Delays or barriers are identified and addressed through structured discussion and follow-up.

Responsible parties are expected to complete assigned activities within established timelines.

11.4 Annual Update

The Work Plan is updated annually to reflect new priorities, performance findings, and system needs. Revisions are approved prior to implementation of the subsequent grant year.

Benchmarks and timelines may be updated without requiring structural revision to the core CQM Plan.

SECTION 12: COMMUNICATION FRAMEWORK

12.1 Purpose

Effective communication supports transparency, accountability, and alignment across statewide Clinical Quality Management Program.

The Nevada Office of HIV maintains structured communication processes to ensure performance data, quality improvement activities, monitoring findings, and program updates are consistently shared with relevant stakeholders.

12.2 Communication Structure

The communication framework below outlines primary audiences, content focus, frequency, and responsible parties.

Audience	Content	Frequency	Responsible Party
CQM Committee	Performance measure review, QI updates, Annual Goal progress	Quarterly	CQM Coordinator
Subrecipients	Performance reports, technical assistance guidance, action items	Quarterly or as needed	CQM Coordinator
Nevada Office of HIV Leadership	Program updates, performance trends, evaluation findings	At minimum annually	CQM Coordinator
HRSA HAB	Required performance reporting, RSR submissions, CQM updates as requested	Per federal reporting schedule	Nevada Office of HIV
Stakeholders / Community (as appropriate)	Summary of program progress, quality initiatives	Annually or as appropriate	Nevada Office of HIV

12.3 Documentation and Record Retention

Meeting minutes, performance reports, technical assistance documentation, and evaluation summaries are maintained as part of the official CQM record.

Communication processes are reviewed annually as part of the overall CQM evaluation.

SECTION 13: APPENDICES

The following appendices support implementation of this Clinical Quality Management Plan and may be updated annually without requiring structural revision to the core document

Appendix A – Annual Quality Goals and Benchmarks

Appendix B – Roles and Responsibilities Table

Appendix C – Performance Measure Portfolio

Appendix D – Annual Work Plan

Appendix E – Communication Schedule

Appendix F – Reporting Timeline

Appendix G – Acronyms and Definitions

Appendix H – Subrecipient SWOT Analysis Roll-Up and Statewide Quality Improvement Alignment

Appendices may be revised as necessary to reflect benchmarks, timelines, performance measures, or reporting requirements.

APPENDIX A

Annual Quality Goals and Benchmarks

April 1, 2026 – March 31, 2027:

Goal 1 – Improve Timeliness and Consistency of Eligibility Verification and Service Utilization

Rationale:

Statewide analysis identified delays and inconsistencies in eligibility verification and service initiation processes impacting timely access to care, data reliability, and performance measurement integrity.

Component	Description
Measure	Percentage of enrolled clients with completed eligibility verification and documented service initiation within 30 days
Numerator	Number of enrolled clients with completed eligibility verification and documented service initiation within 30 days
Denominator	Total number of enrolled clients requiring eligibility verification and service initiation, including initial eligibility and required recertification periods during the measurement period
Baseline	73%
Target	Increase baseline performance by 5 percentage points by the end of the grant year (April 1, 2026 – March 31, 2027)
Data Source	CAREWare/RWISE / Eligibility documentation review
Review Frequency	Quarterly
Responsible Party	CQM Coordinator, Subrecipients

Improvement Strategy:

- Process mapping of eligibility workflow
- Clarification of documentation expectations
- Alignment of monitoring tools
- Targeted technical assistance

Goal 2 – Data Integrity and Documentation Reliability

Rationale:

Variability in documentation and data entry practices impacts performance reporting accuracy and monitoring reliability.

Component	Description
Measure	Percentage of records reviewed with no data entry or documentation discrepancies identified during validation

Numerator	Number of records reviewed with no discrepancies
Denominator	Total number of records reviewed during data validation
Baseline	Baseline will be established using Quarter 1 data to ensure accuracy following completion of the prior April 1, 2025 – March 31, 2026, data reconciliation process
Target	Improve baseline by 5 percentage points once established
Data Source	Data validation review / Monitoring findings
Review Frequency	Quarterly
Responsible Party	CQM Coordinator, Subrecipients

Improvement Strategy:

- Reinforce data entry expectations
- Provide focused documentation TA
- Monitor recurring deficiency patterns

Goal 3 – Strengthen Subrecipient Quality Improvement Engagement

Rationale:

Sustained quality improvement requires active, data-informed participation across funded service categories.

Component	Description
Measure	Percentage of subrecipients implementing at least two documented QI cycles (PDSA) during the April 1, 2026 – March 31, 2027, time period
Numerator	Number of subrecipients completing at least two QI cycles
Denominator	Total number of funded subrecipients
Baseline	70%
Target	Achieve 100% subrecipient participation
Data Source	QI project documentation / CQM reporting
Review Frequency	Quarterly
Responsible Party	CQM Coordinator, Subrecipients

Improvement Strategy:

- Structured coaching
- Targeted QI support
- Review of PDSA documentation

Sharing of lessons learned during CQM meetings

APPENDIX B

Roles and Responsibilities Matrix

Role	Governance	Core Responsibilities
Clinical Quality Management Coordinator (Part B/NMAP/ADAP)	Committee Chair; Operational Lead	<ul style="list-style-type: none"> Leads quarterly CQM committee meetings Develops and maintains the CQM Plan Conducts data analysis and trend review Coordinates technical assistance Integrate monitoring findings with CQM priorities Maintains documentation of CQM activities
Ryan White Part B Coordinator (RWPB)	Committee member	<ul style="list-style-type: none"> Advises on service category priorities Ensures alignment with Part B program requirements Provides policy and compliance guidance relevant to CQM
NMAP/ADAP Coordinator	Committee Member	<ul style="list-style-type: none"> Advises on NMAP/ADAP-related QI priorities Ensures alignment with NMAP/ADAP compliance requirements Supports NMAP/ADAP-related CQM implementation
Ryan White Program Manager	Executive Oversight	<ul style="list-style-type: none"> Holds executive accountability for the CQM program Endorses and champions CQM activities Provides leadership direction and oversight
Subrecipients	Implementation and Participation	<ul style="list-style-type: none"> Maintain timely and accurate data entry Participate in CQM Committee activities Implement QI cycles Report progress and findings Address performance and compliance issues Conduct PDSA cycles and present findings

Data Contractor (Tri-Young)	Data Support	<ul style="list-style-type: none"> • Maintain CAREWare/RWISE systems • Provide reporting support • Assist with data validation and customization
People with Lived Experience (Ad-Hoc)	Advisory Participation	<ul style="list-style-type: none"> • Participate in CQM meetings when applicable • Provide feedback through surveys or focus groups
HRSA HAB	Federal Oversight	<ul style="list-style-type: none"> • Establish federal guidelines and reporting standards

Executive accountability for the Clinical Quality Management Program resides with the Ryan White Program Manager. Operational authority and day-to-day execution of CQM activities reside with the Clinical Quality Management Coordinator.

APPENDIX C

Performance Measure Portfolio

Grant Year: April 1, 2026 – March 31, 2027

Measure Selection Methodology:

Performance measures are selected using a utilization-based tiered framework in alignment with HRSA HAB Policy Clarification Notice 15-02.

- $\geq 50\%$ utilization = minimum two measures
- $> 15\%$ and $< 50\%$ utilization = minimum one measure
- $\leq 15\%$ utilization = no measure required

Only required measures under this framework are listed below.

Service Category	Utilization Tier	Performance Measure	Numerator	Denominator	Target /Bench mark	Data Source	Reporting Frequency
NMCM	≥50%	Service Plan Documentation and Updates	Number of clients receiving NMCM services with a documented service plan that has been updated within the established timeframe during the measurement year.	Total number of clients receiving NMCM services during the measurement year.	85%	CAREWare / Client records	Quarterly
NMCM	≥50%	Assessment and Reassessment Timeliness	Number of clients receiving NMCM services with a completed initial assessment and required reassessments within the established timeframe documented in CAREWare during the measurement year.	Total number of clients receiving NMCM services during the measurement year.	90%	CAREWare / Client records	Quarterly

HIP-CS	≥50%	Percentage of clients receiving Health Insurance Premium and Cost Sharing Assistance who maintain active insurance coverage during the measurement period	Number of clients with documented active insurance coverage	Total number of clients receiving Health Insurance Premium and Cost Sharing Assistance	95%	CAREWare / Program Documentation	Quarterly
HIP-CS	≥50%	Percentage of clients receiving assistance with no lapse in insurance coverage during the measurement period	Number of clients with no documented lapse in coverage	Total number of clients receiving Health Insurance Premium and Cost Sharing Assistance	90%	CAREWare / Program Documentation	Quarterly
HIP-RX	>15% and <50%	Percentage of clients receiving medication assistance with documented medication access during the measurement period	Number of clients with documented medication access	Total number of clients receiving medication assistance	95%	CAREWare / NMAP/ADAP / PBM Data	Quarterly
RHSS	≥50%	Percentage of clients with completed eligibility verification within required timeframe	Number of clients with completed eligibility verification within timeframe	Total number of clients requiring eligibility verification	80%	CAREWare / RWISE / Eligibility documentation	Quarterly



RHSS	≥50%	Percentage of clients with documented referral resulting in service initiation	Number of clients with completed referral and documented service initiation	Total number of clients with documented referrals	85%	CAREWare / Service documentation	Quarterly
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APPENDIX D

Annual Clinical Quality Management Work Plan

Grant Year: April 1, 2026 – March 31, 2027

Domain 1 – Governance & Infrastructure

Objective	Key Activity	Timeline	Responsible Party	Deliverable
Maintain effective CQM governance	Facilitate quarterly CQM Committee meetings	Quarterly	CQM Coordinator	Meeting agendas and minutes
Maintain CQM Plan integrity	Conduct annual review and update of CQM Plan	Q1	CQM Coordinator	Approved updated CQM Plan
Support stakeholder engagement	Incorporate stakeholder and consumer input into CQM discussions	Ongoing	CQM Coordinator	Documented engagement activities

Domain 2 – Performance Measurement

Objective	Key Activity	Timeline	Responsible Party	Deliverable
Conduct quarterly performance review	Extract and review required performance measures	Quarterly	CQM Coordinator	Documented quarterly performance review (data summaries and meeting notes)
Validate data integrity	Review numerator/denominator accuracy and documentation alignment	Quarterly	CQM Coordinator, Data Contractor	Data validation documentation
Identify performance gaps	Review measures below benchmark and discuss during CQM meetings	Quarterly	CQM Coordinator	Performance review discussion documented in meeting minutes

Domain 3 – Quality Improvement

Objective	Key Activity	Timeline	Responsible Party	Deliverable
Strengthen subrecipient QI engagement	Monitor implementation of focused QI cycles	Ongoing	CQM Coordinator, Subrecipients	QI documentation and quarterly updates
Provide structured QI support	Deliver targeted technical assistance based on performance findings	Ongoing	CQM Coordinator	TA documentation and follow-up notes
Promote multiple improvement efforts	Encourage implementation of targeted, data-informed improvement cycles throughout grant year	Ongoing	CQM Coordinator, Subrecipients	PDSA summaries presented at CQM meetings

Domain 4 – Statewide Priority: Eligibility & Service Initiation

Objective	Key Activity	Timeline	Responsible Party	Deliverable
Improve timeliness of eligibility verification	Monitor eligibility and service initiation timeliness data	Quarterly	CQM Coordinator	Documented quarterly review of timeliness performance
Align monitoring and TA with priority	Integrate eligibility workflow review into monitoring discussions	Ongoing	CQM Coordinator	Monitoring documentation reflecting eligibility focus
Support workflow consistency	Provide targeted TA to address eligibility documentation or timeliness gaps	Ongoing	CQM Coordinator	TA documentation and follow-up

Domain 5 – CQM Program Evaluation

Objective	Key Activity	Timeline	Responsible Party	Deliverable
Conduct annual CQM evaluation	Review achievement of Annual Quality Goals and overall CQM effectiveness	Q4	CQM Coordinator	Annual CQM evaluation summary

APPENDIX E

Clinical Quality Management Communication Schedule

Grant Year: April 1, 2026 – March 31, 2027

Purpose

This communication schedule outlines structured reporting and engagement activities supporting the Nevada Office of HIV Clinical Quality Management Program.

Communication Matrix

Audience	Communication Type	Content Focus	Frequency	Responsible Party	Documentation
CQM Committee	Formal meeting	Performance review, QI updates, Annual Goal progress	Quarterly	CQM Coordinator	Agendas and minutes
Subrecipients	Performance Feedback	Performance measure summaries and technical assistance guidance	Quarterly or as needed	CQM Coordinator	Email summaries and meeting notes
Subrecipients	QI Reporting	PDSA updates and improvement cycle discussions	Quarterly	Subrecipients / CQM Coordinator	QI documentation
Nevada Office of HIV Leadership	Program Update	Summary or performance trends, priority focus areas, and CQM evaluation findings	At least annually	CQM Coordinator	Leadership briefing notes
HRSA HAB	Federal Reporting	Required submissions including RSR and CQM updates upon request	Per federal schedule	Nevada Office of HIV	Submitted reports
Stakeholders / Community (as appropriate)	Summary Communication	High-level updates on program progress and quality initiatives	Annually or as appropriate	Nevada Office of HIV	Summary materials

APPENDIX F

Reporting Timeline

Grant Year: April 1, 2026 – March 31, 2027

Purpose

This reporting timeline outlines key Clinical Quality Management-related reporting activities and milestones supporting statewide oversight, performance measurement, and federal compliance.

Annual Reporting Calendar

Reporting Activity	Description	Frequency	Responsible Party
Quarterly Performance Review	Review required performance measures and identify areas below benchmark	Quarterly	CQM Coordinator
CQM Committee Meetings	Review performance data, QI updates, and action items	Quarterly	CQM Coordinator
QI Activity Reporting	Subrecipient submission of PDSA updates and improvement summaries	Quarterly	Subrecipients
Data Validation Review	Review data integrity and documentation alignment	Quarterly	CQM Coordinator / Data Contractor
Annual CQM Evaluation	Review achievement of Annual Quality Goals and program effectiveness	Annually (Q4)	CQM Coordinator
RSR Submission	Federal Ryan White Services Report submission	Per HRSA schedule	Nevada Office of HIV
CQM Plan Review	Review and update CQM Plan for subsequent grant year	Annually	CQM Coordinator

APPENDIX G

Acronyms and Definitions

Grant Year: April 1, 2026 – March 31, 2027

Acronyms

Acronym	Definition
ADAP	AIDS Drug Assistance Program
CAP	Corrective Action Plan
CAREWare	Client-level data management system used for Ryan White HIV/AIDS Program reporting
RWISE	Ryan White Integrated System for Eligibility
CQM	Clinical Quality Management
HRSA	Health Resources and Services Administration
HAB	HIV/AIDS Bureau
OA	Organizational Assessment
PBM	Pharmacy Benefit Manager
QI	Quality Improvement
RWPB	Ryan White Part B
TA	Technical Assistance
RSR	Ryan White Services Report
NMCM	Non-Medical Case Management

Definitions

Clinical Quality Management (CQM)

A structured system to assess, monitor, and improve the quality of services provided to clients, ensuring alignment with federal requirements and improving health outcomes.

Quality Improvement (QI)

A systematic, data-driven approach to improving processes, performance, and client outcomes through targeted and measurable activities.

Performance Measure

A defined metric used to evaluate service delivery, clinical outcomes, or program performance based on established numerator and denominator criteria.

Corrective Action Plan (CAP)

A required plan developed to address identified deficiencies or sustained performance gaps. CAPs include specific actions, timelines, and monitoring requirements.

Technical Assistance (TA)

Targeted support provided to subrecipients to address identified gaps, improve performance, and strengthen program operations.

Organizational Assessment (OA)

A structured evaluation used to assess organizational capacity, processes, and systems that impact service delivery and performance.

SWOT Analysis

A structured assessment identifying strengths, weaknesses, opportunities, and threats to inform planning and quality improvement efforts.

Data Timeliness

The extent to which data is entered, updated, and available within expected timeframes to support accurate and timely performance monitoring.

Workflow Standardization

The process of establishing consistent procedures and practices to reduce variation and improve efficiency and reliability across service delivery.

Quality Improvement Activity

A targeted effort designed to address a specific performance gap or process issue using data-driven methods and measurable outcomes.

Monitoring

Ongoing oversight activities, including site visits and desk reviews, used to assess compliance, performance, and alignment with program requirements.

Statewide Priority Areas

System-level focus areas identified through data, assessments, and analysis to guide quality improvement, technical assistance, and monitoring efforts.

Data-Informed Decision Making

The use of performance data and analysis to guide program decisions, quality improvement activities, and resource allocation.

Ryan White Integrated System for Eligibility (RWISE)

A system used by subrecipients to manage client eligibility, enrollment, and program-related data for Ryan White Part B services.

Lean-Informed Process Improvement

A structured approach to improving processes by identifying inefficiencies, reducing variation, and focusing on activities that add value to client care and service delivery.

APPENDIX H

Subrecipient SWOT Analysis Roll-Up and Statewide Quality Improvement Alignment

Grant Year: April 1, 2026 – March 31, 2027

Purpose

This appendix documents the statewide synthesis of subrecipient SWOT (Strengths, Weaknesses, Opportunities, Threats) analyses conducted as part of Clinical Quality Management (CQM) activities.

The purpose of this appendix is to:

- Identify recurring themes across subrecipients
- Define system-level gaps impacting performance and service delivery
- Establish statewide quality improvement focus areas
- Align subrecipient quality improvement activities with statewide priorities

Findings within this appendix inform quality improvement activities, technical assistance, and monitoring efforts.

Data Source and Methodology

This appendix is based on SWOT analyses submitted by Ryan White Part B subrecipients as part of statewide Clinical Quality Management activities.

The Nevada Office of HIV conducted a structured review and synthesis of subrecipient responses to identify recurring themes, system-level gaps, and opportunities for alignment.

The findings presented in this appendix reflect a statewide interpretation of subrecipient input and are used to inform quality improvement priorities, technical assistance, and monitoring activities.

Statewide SWOT Roll-Up (Derived from Subrecipient Analyses)

Strengths

Across subrecipients, the following strengths were consistently identified:

- Strong multidisciplinary care models supporting integrated service delivery
- Active leadership engagement in CQM activities and performance review
- Experienced workforce with program-specific knowledge and expertise
- Established partnerships supporting referrals, coordination, and access to care
- Existing data systems capable of capturing required program data

Statewide Interpretation:

The Ryan White Part B system in Nevada demonstrates strong foundational capacity in service delivery, infrastructure, and clinical coordination.

Weaknesses

The following system-level weaknesses were identified across multiple subrecipients:

- Data system fragmentation resulting in inefficiencies and delayed data availability
- Inconsistent use of data for routine performance monitoring and decision-making
- Workforce dependency on limited staff, impacting sustainability and continuity
- Variability in workflows across subrecipients, including documentation and data processes
- Capacity constraints limiting consistent execution of quality improvement activities

Statewide Interpretation:

The primary gaps are not related to service availability, but to consistency in execution, data use, and system standardization.

Opportunities

Subrecipients identified several aligned opportunities for improvement:

- Standardization of workflows and documentation practices
- Expansion of structured, routine data review processes
- Increased use of data to inform quality improvement and performance management
- Strengthening partnerships to address social determinants of health
- Targeted training and technical assistance to improve operational consistency

Statewide Interpretation:

Opportunities are consistently aligned across subrecipients, indicating readiness for a coordinated statewide approach.

Threats

The following external and system-level threats were identified:

- Workforce challenges including recruitment, retention, and burnout
- Client-level barriers such as housing instability, transportation, and competing needs
- Increasing administrative and reporting burden
- Funding uncertainty and resource limitations
- External misinformation and service access challenges impacting client engagement

Statewide Interpretation:

External pressures are increasing while internal capacity remains constrained, requiring efficient and coordinated system-level responses.

Statewide Priority Issue

Based on the statewide SWOT analysis, the Nevada Office of HIV has identified the following primary system-level issue:

Primary Statewide Issue

Inconsistent and delayed use of data, combined with lack of standardized workflows, limits the ability to proactively manage performance, support quality improvement, and improve client outcomes.

Statewide Quality Improvement Focus Areas

To address the identified statewide issue, the following focus areas have been established:

1. Data Timeliness and Use

- Establish routine expectations for performance data review
- Improve timeliness and usability of data across systems
- Utilize data to identify trends and inform decision-making

2. Workflow Standardization

- Promote consistent workflows across subrecipients
- Standardize documentation and data entry practices
- Reduce variability in service delivery processes

3. Quality Improvement Execution

- Strengthen consistency in implementation of quality improvement activities
- Ensure quality improvement efforts are data-informed and measurable
- Improve documentation and tracking of quality improvement activities

4. Workforce Capacity and Sustainability

- Reduce reliance on single staff roles for critical functions
- Promote cross-training and role clarity
- Address workflow inefficiencies impacting staff capacity

These focus areas are intended to improve performance consistency, strengthen data-driven decision-making, and enhance client outcomes across the Ryan White Part B system.

Alignment with Subrecipient Activities

Subrecipient quality improvement activities are expected to align with:

- Identified performance gaps
- Data-informed priorities
- Statewide quality improvement focus areas outlined in this appendix

Subrecipients may implement multiple targeted quality improvement activities throughout the grant year based on identified needs.

Activities that do not demonstrate alignment with statewide priorities will be subject to review and may require modification as part of monitoring or technical assistance processes.

Integration with Monitoring and Technical Assistance

Findings from the statewide SWOT analysis are integrated into:

- Monitoring activities, including site visits and desk reviews
- Technical assistance planning and delivery
- Performance review and escalation processes

The Nevada Office of HIV utilizes this alignment to ensure consistency between:

- Identified system gaps
- Quality improvement efforts
- Monitoring and oversight activities

Identified gaps may result in targeted technical assistance, required quality improvement activities, or corrective action, as appropriate.

Use and Maintenance of This Appendix

This appendix is maintained as part of the Clinical Quality Management Plan and may be updated as needed to reflect:

- Updated SWOT findings
- Organizational Assessment results
- Emerging statewide priorities
- Changes in program needs

Updates to this appendix do not require structural revision to the core CQM Plan.