

CQM COMMITTEE MEETING

September 24, 2026

Meeting started at 10:00am – ended at 11:52am

In Attendance:

Twenty-four participants attended the meeting:

Jeremy Hurley, Karina Bir, Carolyn Chavez, Bernadette Villarruel, Erin Arreola, Princette Bowling, Anastasia Kime, Kristopher Pre, Lorena Lemus, Martin Gapultos, Lorianna Angel-Guadron, Bobby Milam, M. Gabriel Colbaugh, Auston Carlson, Sherria Taylor, Ronny Soy, Ericka Gonzalez, Karina Ponce, Victor Hernandez, Marcos Paez, Sean Jaureuito, Sarah Cowan, Gina Schuster, Sean Needham

AGENDA:

Performance Measure Review

The Committee reviewed the Grant Year 2026-2027 Clinical Quality Management performance measures and available Quarter 1 findings. Discussion focused on determining whether the measures can be reliably calculated using current data systems and documentation practices, identifying changes resulting from implementation of centralized eligibility, and identifying areas requiring additional clarification or validation.

Committee members were advised that preliminary or unexpected performance results should be validated before determining that a performance problem exists or initiating a quality improvement activity.

Measure 1: Non-Medical Case Management Service Plan Documentation and Updates

The Committee discussed current practices for documenting service plans and service plan updates.

- Documentation practices vary across organizations and may include both electronic medical record systems and CAREWare.
- CAREWare General Monitoring may be used for service plan follow-up but is also used for other activities, limiting the ability to identify service plan updates through a report.
- Committee members discussed whether service taxonomy could be modified or standardized to make service plan activities easier to identify and report.
- Current service standards and existing service categories should be reviewed before determining whether a new service category is necessary.
- Service plan review frequency may vary based on client acuity, organizational workflow, and existing service standards.

Follow-Up: CQM and program staff will further review service taxonomy, service standards, documentation practices, and potential reporting options before finalizing the measurement methodology and timeframe.

Measure 2: Non-Medical Case Management Assessment and Reassessment Timeliness

The Committee discussed the assessment and reassessment measure and the effect of centralized eligibility on the current workflow.

- Eligibility and case management activities are no longer necessarily completed as part of the same process.
- Referral to a case management organization does not necessarily result in immediate client engagement or completion of an assessment.
- Client responsiveness and unsuccessful outreach attempts may affect the time between referral and assessment.
- Committee members emphasized the importance of documenting outreach attempts when clients cannot be reached.
- Current data and workflow should be further reviewed before interpreting a low performance result as a failure to complete required assessments or reassessments.

Follow-Up: CQM and program staff will continue reviewing the measure methodology, denominator, applicable service documentation, and the effect of centralized eligibility on assessment and reassessment timeliness.

Measure 3: Health Insurance Premium and Cost Sharing Assistance - Active Insurance Coverage

The Committee discussed how active insurance coverage and utilization are currently verified.

- Insurance utilization may be supported through claims information, Explanation of Benefits documentation, invoices, and other documentation showing insurance processing and member responsibility.
- Discussion identified challenges with using existing CAREWare service data to independently determine whether all clients receiving Health Insurance Premium and Cost Sharing Assistance maintained active coverage.
- Current service taxonomy primarily captures payments and may not contain all information necessary for the proposed performance measure.

Follow-Up: CQM and program staff will further review available data sources and determine whether the measure can be reliably calculated using current reporting processes or requires modification.

Measure 4: Health Insurance Premium and Cost Sharing Assistance - No Lapse in Insurance Coverage

- The Committee discussed the challenges associated with determining whether clients experienced a lapse in insurance coverage.
- Coverage changes may not always be known immediately.
- Current CAREWare payment information may not provide sufficient information to independently identify all coverage lapses.

- The current structure of Health Insurance Premium and Cost Sharing Assistance services creates limitations for developing two distinct measures from existing service data.
- Committee members discussed alternative information that may be available through internal tracking or supplemental documentation.

Follow-Up: CQM and program staff will continue reviewing the Health Insurance Premium and Cost Sharing Assistance measures to determine whether revisions are necessary and what data can be reliably reported.

Measure 5: Health Insurance Prescription Drug Assistance - Medication Access

The Committee reviewed the Quarter 1 medication access measure, which used documented medication payments as an indicator of medication access.

- Quarter 1 identified clients without a documented medication payment.
- Committee members identified several circumstances that could affect the measure, including clients reaching insurance out-of-pocket maximums, differences between copay and full-pay claims, and clients using other pharmacy assistance.
- The date that payment information is uploaded into CAREWare may differ from the actual medication fill date.
- Committee members discussed whether pharmacy benefit manager claims data could provide a more accurate source for medication fill information.
- The Committee also discussed whether the measurement period or measure definition should be modified to more accurately reflect medication access throughout the grant year.

Follow-Up: CQM and program staff will further evaluate pharmacy benefit manager claims data, CAREWare data, and alternative measurement approaches before finalizing the methodology for subsequent reporting periods.

Measure 6: Referral for Health Care and Support Services - Eligibility Verification Timeliness

The Committee discussed how centralized eligibility affects the eligibility verification timeliness measure.

- Current Eligibility Start Date in CAREWare does not independently represent the initiation and completion dates needed to calculate processing time.
- Eligibility may be completed the same day when clients present all required documentation.
- When documentation is incomplete, the amount of time required to complete eligibility may depend on when the client provides the missing information.
- The centralized eligibility process generally does not initiate the RWISE application until required documentation is available.
- The Committee discussed whether the existing measure remains the most appropriate way to evaluate the centralized eligibility process.

Follow-Up: The measure will continue to be monitored while the centralized eligibility process matures. CQM and program staff will review available RWISE and CAREWare data and determine whether the measure should be revised during a future reporting period.

Measure 7: Referral Resulting in Service Initiation

The Committee reviewed the preliminary referral-to-service-initiation measure and discussed how centralized eligibility has changed referral workflows.

- Centralized eligibility now generates referrals to case management organizations.
- AHN reported that referral information can be obtained from the RWISE domain and cross-referenced with internal appointment information.
- Other organizations may document receipt of referrals in CAREWare and use internal electronic medical record systems to document outreach and follow-up activities.
- The Committee discussed the need to distinguish between a referral being received or closed and the client actually initiating the referred service.
- Unsuccessful outreach and clients lost to follow-up create additional questions regarding how referral outcomes should be classified.
- Current referral workflows differ from the workflows that existed when the performance measure was originally developed.
- Additional guidance may be necessary to standardize referral documentation and determine what constitutes successful service initiation.

Follow-Up: CQM and program staff will review the referral measure in the context of centralized eligibility and determine whether the measure definition, documentation expectations, reporting methodology, or additional guidance should be revised.

Cross-Cutting Performance Measure Findings

- Documentation practices are not consistently structured for performance reporting.
- Some measures require clearer definitions, standardized fields, timeframes, or workflows.
- CAREWare alone does not contain all information necessary to calculate every performance measure.
- RWISE, pharmacy benefit manager data, internal organizational systems, or supplemental subrecipient data may be necessary for some measures.
- Centralized eligibility changed several workflows after the performance measures were originally developed.
- Preliminary and unexpected performance results should be validated before conclusions are made regarding program performance.
- Performance measures may require refinement during the grant year when program operations or available data change.

The Committee discussed the importance of verifying performance results, understanding whether an identified issue relates to performance, workflow, documentation, or data, and using formal quality improvement when a validated and actionable performance gap is identified.

Quality Improvement Project Updates

Northern Nevada HOPES

Northern Nevada HOPES is completing its previous retention-in-care project and beginning a new data validation activity. Staff are conducting a comprehensive chart review of HIV clients to validate information including last visits, laboratory information, eligibility dates, primary care status, relocation, and deceased status. The activity is intended to improve data accuracy and support outreach efforts.

AIDS Healthcare Foundation

AIDS Healthcare Foundation reported completion of the first cycle of its quality improvement project and development of an internal performance measure dashboard for

Non-Medical Case Management. Initial dashboard results showed 78 percent performance for service plan documentation and updates against an 85 percent target and 65 percent for assessment and reassessment timeliness against a 90 percent target. During the second cycle, staff are reviewing records that do not meet the measures to distinguish actual documentation or timeliness gaps from clients who should not be included in the calculation. The organization will continue working with data staff to refine dashboard logic and use findings to inform a future intervention.

Access to Healthcare Network

Access to Healthcare Network provided an update on its centralized eligibility quality improvement project. The project focuses on strengthening workflows and monitoring the new eligibility process. Reported active-client rates increased from 91.5 percent in July to 91.9 percent in August and 92.3 percent in September. Improvements implemented during the quarter included increased appointment availability, addition and training of two eligibility staff, and workflow changes intended to increase staff capacity.

Southern Nevada Health District

Southern Nevada Health District identified a documentation gap involving referrals to organizations outside of the Ryan White system. These referrals were not consistently captured in CAREWare. The organization developed a workflow involving case management, care coordination, and community health workers to improve referral documentation and follow-up. The project continues to monitor referral documentation, with a goal of increasing documented referral activity by December 2026.

Aid for AIDS of Nevada

Aid for AIDS of Nevada continues monitoring performance related to referrals and care plans by quarter. Quarter 1 was completed, and the organization is reviewing trends and opportunities for improvement as Quarter 2 data become available.

Community Health Alliance

Community Health Alliance reported implementation of an improved pharmacy workflow to strengthen communication, medication tracking, ordering, and prior authorization processes. The organization's next quality improvement activity will focus on developing improved educational materials for clients who are new to the Ryan White program. The materials are intended to help clients understand available services, contacts, and connections to community resources.

Community Outreach Medical Center

Community Outreach Medical Center reported purchasing a new electronic medical record system. The organization expects the new system to improve data collection, identification of gaps in care and missed appointments, follow-up activities, patient outcomes, and program reporting. The organization also introduced its new compliance officer, Sean Needham.

Next Steps

- Continue collecting and analyzing performance measure data.
- Review performance measures affected by centralized eligibility or current data limitations.
- Determine whether additional guidance, standardization, or revisions are necessary for specific performance measures.

- Continue validating preliminary or unexpected performance results before determining whether formal quality improvement activities are necessary.
- Continue communication and resource sharing among CQM Committee members and subrecipients.
- Incorporate Committee feedback into ongoing performance monitoring and CQM activities.
- Distribute meeting minutes following the meeting.

Next Meeting

The next CQM Committee meeting is tentatively scheduled for December 10, 2026.