
# New Jersey HIV Clinical Quality Management Plan

Ryan White Part B

NJDOH

# Table of Contents

# I. Quality Statement

**Purpose**: The purpose of this document is to establish guidelines that ensure consistency in the delivery of high-quality HIV care and equitable access to services across all Ryan White Programs. The goal is to establish a comprehensive and efficient system of care that is client-centered, system-focused, data driven, team-oriented, and adaptable to changing circumstances. This document will:

- Provide a clear understanding of clinical quality management (CQM) activities in Ryan White programs for all stakeholders.
- Describe the quality management infrastructure.
- Establish roles, responsibilities, and expectations for all components of the Quality Management Program.
- Identify annual quality management goals for subrecipients; and
- Guide the development of future quality management activities in the State.

**Vision**: To provide a continuum of care and support services that promotes optimal health, decreases new HIV infections, aligns with the Ending the HIV Epidemic plan, ensures equitable and unfettered access to services, reduces health care disparities, empowers clients and promotes self-determination, as well as meets the needs and expectations of staff and clients.

**Mission**: The New Jersey Statewide HIV Clinical Quality Management program exists to ensure the highest quality HIV care for people living with HIV/AIDS (PLWHA) in New Jersey through statewide leadership and stakeholder collaboration.

# II. Infrastructure

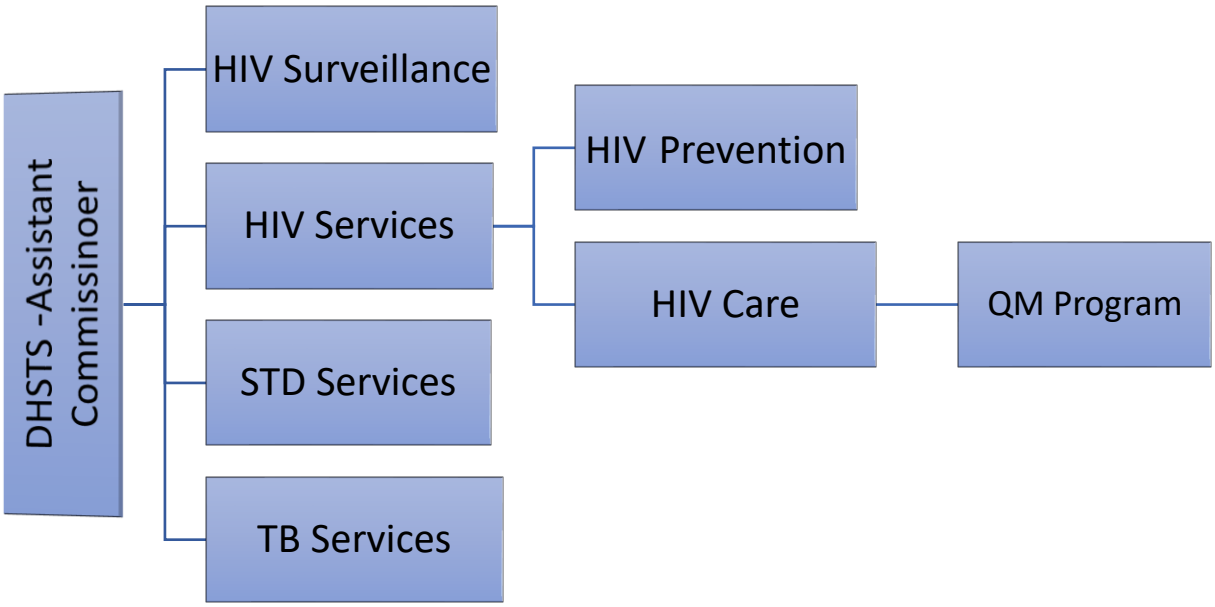
**Oversight:**

The quality management efforts of the NJDOH HIV Care and Treatment Services are led by the Executive Director of HIV Services within the Division of HIV, STD and TB Services (DHSTS), New Jersey Department of Health. This Office is responsible for developing integrated HIV care and prevention programs and services designed to address the needs of persons with, or at risk for HIV (see table #1). The Care & Treatment program serves as the Health Resources and Services Administration's (HRSA) Ryan White Part B (Title II) grant recipient in New Jersey and administers care activities, which include the AIDS Drug Distribution Program (ADDP) and the Health Insurance Premium Payment Program (HIPP), Housing Opportunities for Persons with AIDS (HOPWA), Minority AIDS Initiative and the regional HIV Care Services.

Office of the Executive Director provides leadership and support to funded agencies through the provision of resources, education, training and technical support. Day-to-day QM initiatives are coordinated by the office's Clinical Quality Management Coordinator. A significant portion of HIV Care and Treatment's day-to-day QI work is conducted through contract with a staff

team of the Francois-Xavier Bagnoud Center (FXBC), which is a family-centered HIV care program, part of School of Nursing of Rutgers State University of New Jersey. On behalf of the HIV Care and Treatment program, the FXBC team conducts a number of key tasks for the NJDOH Ryan White Part B (state) program: conduct on-site chart reviews and ensure QI projects are generated, as appropriate; coach sites on quality improvement methodology, help sites strengthen their QM infrastructure, and guide them in implementing effective HIV QI activities; serve as active members of the NJ DOH HIV QM Steering Committee, providing input from the field and help guide statewide HIV QM efforts.

**QM Program Line of Authority (December 2020)**




NJ HIV Clinical Quality Management Leadership Steering Committee

The NJ DOH HIV QM Steering Committee began in early 2016 and held its first meeting in June. Creation of the Steering Committee was set into motion by a HRSA site visit in the fall of 2015 which recommended that the department create a coordinated, comprehensive approach to HIV CQM. The Steering Committee has representatives from the consumer community; Ryan White Parts A, C, D and F; Part B Program Services; DHSTS Partner Services; ADAP; and the HIV Planning Group. The Ryan White representatives reflect the spectrum of services provided with PWHAP (medical, dental and supportive services).

The Role of the Cross-Part Collaborative[1]

A special initiative of New Jersey's HIV quality management efforts is the Cross-Part Collaborative (CPC). It was established in 2008 when the national Ryan White Program invited several states to take part in a nationwide HIV quality improvement initiative. Since then the

[1] The Cross-Part Collaborative (CPC) is an initiative of the NJ DOH HIV Program. The Part D Director of the Division of Family Health Services is dedicated to coordinating the CPC.

CPC has coordinated NJ DOH's participation in the Ryan White Program's in+care campaign and the H4C initiative, focused on improving performance on indicators included in the National HIV/AIDS Strategy. The measures address retention in care, ARV prescribing, and HIV viral suppression. Although the H4C ended, New Jersey has continued to collect this data through the Cross-Part Collaborative. Measures are submitted every two months by Ryan White funded programs in the state, either directly or through the Part A and D networks. The CPC also ran a cohort initiative, which showed improvement in the VLS rate among RW agencies. The CPC was adjusted to align with the end+disparities initiative in New Jersey (see "Identifying and Addressing Health Disparities," below.)

The CPC committee meets quarterly; the committee's progress is reported regularly to the Steering Committee. The CPC is coordinated by the NJ DOH staff member who is also the Director of NJ DOH'S Ryan White Part D Program (Ryan White Part D work, which focuses on women, children, infants and adolescents, is housed within the NJ DOH Division of Family Health Services). The committee is a part of the larger Quality Management Program through the Department of Health, HIV, TB and STD services.

Persons living with HIV who receive Ryan White funded services in New Jersey play a key role in the NJ DOH HIV QM effort. For example, they serve as members of the Steering Committee and its subcommittees, and on the CPC committee. Consumers have taken the lead in providing HIV QM training to other consumers around the state through in-person trainings and webinars. Several consumers have been active members of the Quality Management Program.

Steering Committee work is guided by the annual Work Plan **(see Attachment 1).**

The Steering Committee creates subcommittees as needed. Currently subcommittees have been created to focus on:

- Developing a comprehensive HIV statewide quality management plan;
- Consumer input and infrastructure development;
- Medical indicators;
- Supportive services;
- Oral Health Care;
- Data and CAREWare support

The Steering Committee meets in-person each quarter. Subcommittees may meet more frequently while a task is underway; meetings are conducted either in-person or virtually.

**Steering Committee Structure**


## III. Performance Measurement

- **Spectrum of Services**

Measurement of performance of the NJ HIV care program reflects the spectrum of Ryan White services that are funded. These include: HIV primary care (adult, adolescent and pediatric); nutrition support; case management (medical and non-medical); mental health services; substance use services; psychosocial support; oral health care; other services; medical transportation; outreach/discharge planning; housing assistance (short-term emergency); and financial assistance (emergency).

- **Selection of Performance Measures**

The HIV QM Steering Committee identifies the source for QM measures and priorities that will be pursued annually. The FXB CQM team and the CPC Committee may make recommendations for measures and priorities. For example, consistent with national Ryan White priorities, the CPC's project is focused on HIV patient retention, ARV prescribing, and viral suppression.

Performance measures are reviewed by the Steering Committee at least annually as part of its year-end QM program evaluation. Selection and definition of measures and prioritization of QI activities are revised annually in response to performance data and information about emerging needs.

- The Steering Committee focuses on at least three categories of performance measures: process, outcomes, and satisfaction. A high-priority process measure, for example, is whether HIV positive women are provided with regular cervical cancer screening. A high-priority outcome measure is the percentage of HIV positive clients who have reached HIV viral suppression. Client satisfaction measures are currently identified by individual recipients.

- Identifying Disparities in Care

The Steering Committee is also concerned about disparities in care, a priority of the National HIV/AIDS Strategy (NHAS). Disparities data on key HIV performance measures are collected every two months from all Ryan White-funded medical providers in the state. The Steering Committee also considers data from New Jersey's unmet HIV needs studies to determine if QI efforts should be directed towards particular subpopulations. Current priorities include young men who have sex with men (MSMs), particularly African American and Latino. Data indicate that many facets of their care have suboptimal performance: linkage to care, retention in care, and mental health services. *(See also "Identifying and Addressing Health Disparities, below.)*

- Role of Cross-Part Collaborative in Performance Measurement

For many years, the CPC has been a major receiver of HIV performance data. Data from all Ryan White funded programs, direct recipients as well as subrecipients, are submitted to the CPC Coordinator every two months. Many programs report their data directly; some report through their Part A or D structures. These data have focused on high-priority indicators of the in+care and H4C and now End-the-Epidemic campaigns—particularly patient retention and HIV viral suppression.

- Generating Performance Data

Providers generate data from various sources including web-based platforms and information systems. All Part B funded agencies use CAREWare to input and report client-level data and services to DHSTS. Reports are generated quarterly. Reports generated from CAREware are used to guide program planning, improve service delivery, evaluate provider clinical performance, and comply with HRSA/HAB reporting requirements on HAB Performance Measures and client-level data. Many clinical providers also utilize various electronic health record systems to track client data and performance measurements. Surveillance data regarding unmet needs and continuum of care are generated through various means including Electronic HIV/AIDS Registries (eHARS) and Mortality and Morbidity reports, as well as specialized surveys targeting hard-to-reach communities and groups. eHARS is a repository of HIV/AIDS case reporting. It captures in-care data by tracking HIV viral loads and CD4 reporting.

Individuals with at least one HIV viral load test in measurement year and/or one outpatient medical care visit are considered to be in care.)

- Processing and Validating Performance Data

HIV performance data are prepared by staff and shared with the Steering Committee, the CPC committee, and the FXB team. Significant work on receiving and compiling HIV performance data is performed by the CPC Coordinator, who receives data every two months on key performance measures from all Ryan White funded clinical programs statewide. These are shared with HIV Care and Treatment program leadership, with the CPC committee and then with the Steering Committee. Data are displayed in table and graph format so they can be interpreted more easily and accurately, and trends identified. The National Quality Center (NQC now Center for Quality Improvement and Innovation) also feeds back tables and graphs related to priority H4C indicators. Additional data are compiled, formatted and shared on special project initiatives—e.g., the Steering Committee's Oral Health QI project and improvement on STIs Screening.

Staff review incoming data, compare them to benchmarks, and look for patterns in data submitted by individual providers, in order to validate accuracy. The FXB team conducts on-site visits to clinical providers where charts are reviewed and inconsistencies in data reports can be identified.

- Technical Assistance from Center for Quality Improvement and Innovation (CQII)

The NJDOH HIV QM program's work on performance measurement has received technical assistance from HRSA's Ryan White HIV/AIDS Program Center for Quality Improvement and Innovation (CQII) coaches. There have been individual sessions with the coaches and leads in the program as well as educational sessions for the whole committee.

## IV. Annual Goals and Projects

Quality performance goals reflect all Ryan White funded services: primary medical, medical case management, dental, medical nutrition therapy, mental health services and supportive services. The measures being tracked are consistent with HIV/AIDS Bureau performance measures and NJ DOH contracts.

Performance on key indicators is measured bimonthly. Indicators are either process ([P]), outcome ([O]) or satisfaction ([S]) measures, as described in "Selection of Performance Measures" above.). As noted in Attachment 2, these include:

- Viral Suppression[O]
- Gap[O]
- Medical Visit Frequency[O]
- ARV Prescribing[P]
- Oral Health Care[P]
- Late HIV Diagnosis (Early Identification) [P]
- Linkage to Care[P]
- Health Insurance[P]
- Housing Status (Stable)[P]

Additional indicators are measured annually. Also noted in Attachment 2, these include:

- Medical Case Management (Care Plan) [P]
- Mental Health (Depression Screening, Plan and Care)[P]
- Psychosocial Support[P]
- Nutrition Therapy[P]
- Legal Services
- Medical Transportation[P]
- Outreach/Discharge Planning[P]
- Housing Assistance (Short-Term Emergency) [P]

Measures on the Bimonthly and Annual lists are reviewed and revised by staff and the Steering Committee annually to reflect emerging priorities. Bimonthly and annual data reports are submitted by staff to the Steering Committee.

Baseline data (percentage performance levels at the close of the previous year) are determined by committee members. Annual target goals are drafted by staff and determined by the Steering Committee. Generally, performance levels are set between 50 and 90%, oral health being the lowest at 50%. The majority are at 90%.

The data grid (Attachment 2) is used to report data on a bimonthly and annual basis. Each time the Steering Committee holds its quarterly meeting it receives, and reviews data reports generated since the previous meeting.

Performance measures currently include process and outcome measures. A Consumer Input and Infrastructure Development Subcommittee select Consumer Satisfaction measures which will be added to the data reporting grid for the 2021-2022 cycle.

The Steering Committee selects QI project priorities, based upon performance data. In doing so the SC considers:

- Frequency—does this indicator affect a significant number of clients?
- Impact—is the impact on clients' health and well-being serious?
- Feasibility—is it possible to address this concern effectively through a QI project?

Based on performance data and information from the NJ Department of Health, the committee chose STI screening as a statewide QI project for the 2019-2020 cycle. The Steering Committee's monitoring of key quality indicators includes three major indicators; programs statewide continue to pursue HIV viral suppression improvement efforts as part of their participation in the End-the-Epidemic initiative.

The Steering Committee and staff encourage programs to use the PDSA (Plan-Do-Study-Act) methodology when implementing QI projects.

## V. Participation of Stakeholders

Effectively engaging internal and external stakeholders in HIV QM efforts is essential to the success of these efforts in the state. Stakeholders bring different expertise and perspective and play different roles in the QI process.

**Internal: DHSTS/DOH Staff Participation**

DHSTS plays a leadership role and supports quality development with training programs and facilitates staff participation in the process by ensuring that time and resources are allocated for QM activities. NJ Department of Health facilitated training on CQI methodology. Other training opportunities are coordinated with assistance from the Center for Quality Improvement and Innovation (CQII) and AIDS Education and Training Center (AETC), that provide in-person multi-sessions training on data drill-down including process mapping and systems change to manage patient level data and provide targeted interventions to clients. Subrecipients are also encouraged to utilize on-line training modules available through the Target Center (Health Resources and Services Administration).

Staff engaged in CQM are led by the Executive Director of HIV Services who provides administrative and programmatic oversight to the CQM program, including strategic planning

to enhance and lead HIV care and treatment services by promoting and disseminating evidence-based interventions and innovative approaches to care; enhancing and developing strategic partnerships with clinical and support services providers across the state; promoting data utilization to measure care quality, and informing and supporting program planning and improvement efforts.

The Quality Management Coordinator is responsible for day-to-day leadership of the CQM program including the development, implementation, and evaluation of the Quality Management Program in partnership with internal/external stakeholders; selection of annual performance measures; setting QI priorities and coordinating QI projects and activities.

The Data Analyst coordinates data collection and monitors utilization patterns to support QI projects and activities and priority-setting relevant to annual goals and the quality management program overall; and provides technical assistance to care providers regarding CAREWare utilization, software updates and desk-side assistance.

**Subrecipient participation**: DHSTS funds forty-nine subrecipients to provide direct services to clients in the treatment and prevention of HIV. These include community clinics, AIDS service organizations (ASO), community-based organizations (CBOs) and local health departments.

Subrecipients are required to submit regular reports, using a standardized template, on all QI projects and activities to the Part B team for review, evaluation and feedback; provide DHSTS with requested performance data for each respective service category; attend quarterly quality committee meetings; develop and sustain site-specific improvement projects; provide feedback to funders; and actively participate in statewide QI activities. Providers will report baseline and improvement goals, as well as site specific improvement strategies and barriers. The team will provide feedback via regular emails or in-person meeting when appropriate, will identify and endorse effective strategies, track progress, and provide technical assistance, if needed.

Each provider agency and program are responsible for developing its own QM program and conducting at least one QI project, annually. QM plans must include the following elements:

- QM program leadership.
- QM infrastructure.
- QM plan development.
- Training and engagement of staff in QM.
- Performance measurement, including annual goals for generally accepted measures, and communication of performance data to the State.
- Particular attention to performance on key outcome measures relevant to viral suppression and patient retention.

- QI projects based upon data and using standard QI project methodology (e.g., PDSA).
- Participation of consumers and other stakeholders in QM.
- Identifying and addressing health disparities.
- Plan to sustain improvement.
- Annual process of evaluating its QM program.

Although subrecipients are expected to align their QI activities with those of Part B priorities, service providers may carry out additional QI projects based on their local needs or the unique needs of the populations they serve. Subrecipient agencies are invited to be members of the NJ Quality Management Steering Committee, so their input is integrated into the state's HIV QM efforts.

**Consumer participation**: There have been statewide efforts to educate consumers, build consumers' capacity and ensure their active participation in all quality management programs and QI activities in the state. Consumer training began in 2014 by consumer advocacy groups, supported by community partners, planning bodies, and Ryan White funded providers across the state to ensure consumer participation in:

- QM Committees and QI work groups;
- Needs assessment surveys, satisfaction surveys, and advisory boards;
- QM Committee meetings; and
- QI projects.

In 2018 DHSTS sponsored a 5-day training of consumers in quality program through AETC in collaboration with the Center for Quality and Improvement and Innovations. Twenty-five consumers from Part B and Part A participated in this training and are now incorporated into QI teams at service providers agencies and actively participate in QI activities.

**Clinical Quality Management Steering Committee:** members of CQM SC consist of medical providers; medical case managers; mental health/substance use providers; support services providers; representatives from Parts A, B, C, D and, F; ADDP; Planning Group, and consumers. It provides oversight for all QI activities, including:

- Developing and implementing the statewide Ryan White Part B QM Plan and ensuring adequate resources to carry out the annual QM work plan;
- Developing priorities and setting QI goals;
- Participating in quarterly meetings to review system-wide QM issues and challenges, and developing strategies to improve care;

- Planning and developing educational strategies for Ryan White-funded providers; and
- Participating in annual evaluation to review performance outcomes and QI activities; to determine statewide quality initiatives and performance indicator benchmarks; and to set goals and priorities for the new year.

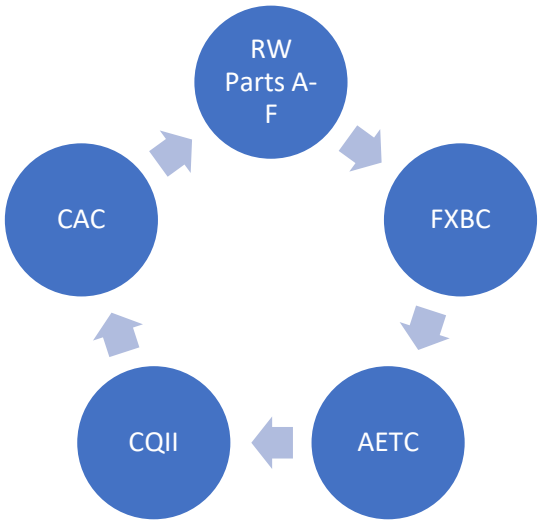
The steering committee also designated specific roles/functions to facilitate and coordinate QM activities:

- Leader:
    - Provides leadership within the Team to ensure progress over the course of the collaborative efforts.
    - Coordinates Team activities and provides encouragement to the members and providers statewide.
    - Ensures that all points of view are heard and represented throughout the course of the collaborative.
    - Works to ensure that Team timelines are met.
    - Represents the Team within the State and advocates to external stakeholders about the achievements of the Team.
    - Disseminates information, training aids, statewide reports, and training opportunities to all providers via email and through the
    - Maintains and updates contact information for all RW medical providers in New Jersey.
    - Helps establish “buddies” to link experts with a provider in need of TA.
    - Provides ongoing telephone support and encouragement.
    - Works to ensure active participation in the collaborative effort by all 40 RW medical providers in New Jersey.
- Data Liaison/Steward (Collects and reports CPC data and state QM reports):
    - Maintains the statewide data set and disseminates a statewide aggregate report each cycle to all New Jersey providers.
    - Provides leadership in the needs assessment of New Jersey subrecipients regarding the understanding of the collaborative indicators and how the data elements are defined.
    - Provides leadership in the needs assessment of New Jersey’s 40 medical providers regarding their capability to submit accurate data to the collaborative.

- Assists in the design and implementation of statewide training programs related to data management, to help providers meet the requirements of the collaborative project.
- Creates training aids related to data and posts them on the NJ web space, and then submits to the Alignment Officers for wider dissemination.
- Is available to respond to questions from grantees and/or providers either by phone or email that relate to client level data collection and aggregate reporting.
- Brings issues and concerns related to data from the providers to the Team.

**Other stakeholders**: DHSTS directly collaborates with Part A funded programs and planning councils (EMAs and TGAs); Part C, Part D and Part F. These collaborations allow Ryan White programs to maximize resources, eliminate duplication of efforts and services, and ensure equitable access to high quality care. Each of these entities has representation in the QM Steering Committee and actively participates in QI activities.

**Collaborating Partners**




## VI. Identifying and Addressing Disparities

Data on high-priority quality indicators are stratified periodically by gender, race/ethnicity, age and insurance status in order to identify disparities in care experienced by subpopulations of persons with HIV.

Collection of disparity data began with the H4C initiative. Data are collected and stratified every two months. The three measures collected are: Gap, ARV Prescribing, and Viral Suppression. Stratified data are reported by individual programs and compiled into an aggregate statewide

report. These data are shared with all members of the Steering Committee. The committee is preparing to add a once yearly report stratified by housing, mode of transmission, gender and age (gender and age are already collected). The CAREWare report has been written and tested. It will be implemented after January 2021.

If disparities data show that a subpopulation of clients is experiencing suboptimal outcomes, staff and the Steering Committee determine what improvement efforts should be implemented to close the disparities gap.

Progress in closing disparities will be monitored on key indicators through bimonthly data reports and will be a component in the Steering Committee's year-end QM program evaluation.

## VII. Sustaining Improvement

Once a quality initiative has addressed a facet of care and improvement has been achieved, the Steering Committee continues to measure and monitor performance on that indicator to ensure that the improvement is sustained. If it drops to 10% or more below the target goals, the SC determines how to intervene and once again improve performance in that area.

Using approaches such as the PDSA QI project methodology, the NJ HIV QM effort encourages programs to achieve improvement by changing their processes and systems. This includes, for example, changing clinical procedures, revising forms, upgrading equipment, ensuring access to supplies, and regular staff in-service trainings. In this way, successful interventions are embedded into the clinical programs' daily work.

## VIII. Communication

Communicating information about quality improvement activities and providing opportunities to learn about quality are necessary for both internal and external stakeholders.

The purpose of the Steering Committee communication plan is to:

- engage all Ryan White funded providers, consumers and other key stakeholders in the quality improvement process;
- support quality improvement efforts in New Jersey;
- improve health outcomes for all individuals living with HIV/AIDS; and
- reduce health care disparities across populations and communities to achieve sustainable viral suppression.

The ultimate goal of this endeavor is to promote a culture of quality through information-sharing; disseminating best practices; sharing research and evaluation findings; and making education and training opportunities available to members and providers.

The Steering Committee will utilize various channels of communication to report to and receive information from stakeholders. These include in-person meetings, email lists, web-based platforms, newsletters, conference calls and webinars.

In addition, membership in planning bodies and health care professional organizations provide the mechanism for committee members to communicate successes of QI projects to wider audiences and to receive feedback regarding the changing needs of persons with HIV.

## IX. Evaluation

The New Jersey Department of Health HIV Quality Management Program will be evaluated within one month of the close of each program year. The evaluation will be prepared by staff and a subcommittee and submitted to the full Steering Committee at its first meeting of the new program year.

- The annual evaluation will, among other things, consider if: Trends in performance data are positive.
- Performance targets were reached.
- Performance on key indicators (retention and HIV viral suppression) is favorable in relation to national benchmarking data.
- The NJ HIV QM Steering Committee has been effective in guiding statewide QM efforts.
- QM infrastructures at the individual program and state level have been strengthened. (Useful tools for this purpose are QM Organizational Assessment forms available from NQC.)
- QI projects at the level of individual programs and the state have achieved the planned impact.
- Consumer involvement in quality improvement activities has been maintained and expanded. The annual evaluation will be used to revise this QM plan, responding to the above factors, new standards, and emerging needs. Each year's QM plan will:

The annual evaluation will be used to revise this QM plan, responding to the above factors, new standards, and emerging needs. Each year's QM plan will:

- Provide the vision and organization needed for future quality initiatives.
- Adjust the QM infrastructure if needed, so that future QM efforts will be increasingly effective.

- Consider adding, deleting or revising quality measures depending on national and state-level expectations, new clinical standards, and emerging local needs.
- Establish percentage-level targets for all indicators, with the intent to create “stretch” goals at all program levels.
- Identifying high-priority facets of clinical care on which the new year’s QI initiatives should focus.
- Include activities to further strengthen consumer involvement in QI.

**NEW JERSEY DOH HIV QUALITY MANAGEMENT—WORK PLAN 2020-2021 Attachment 1** Attachment 1

| | Apr 2020 | May | Jun 20202020 | Jul 2020 | Aug 2020 | Sep 2020 | Oct 2020 | Nov 2020 | Dec 2020 | Jan 2021 | Feb 2021 | Mar 2021 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **STEERING COMMITTEE** | | | 1st Qtr meeting | | | 2nd Qtr Meeting` | | | 3rd Qtr Meeting | | | 4th Qtr Meeting |
| **QM PLAN** | | | | | | | | | | Review | | |
| **PERFORMANCE MEASUREMENT** -by CPC | Report Jan-Dec | | Report March-Feb | | Report May-Apr | | Report July -June | | Report Sept -Aug | | Report Nov - Oct | |
| | | | | | | | | | | | | |
| -Medical Indicators Subcommittee | | | | | | | | | | | | X |
| -Support Services Subcommittee | | | | | | | | | | | | X |
| **QI PROJECTS** (with attention to disparities, and engagement of consumers) -Screening for STIs | | Team Mtg and presentation | | | | Present assmt form to SC | Distribution statewide | Receive assmt results | Report assmt results to SC | Launch QI projects statewide | → | → |
| -Consumer QI Project (TBD) | | | | | | | | | Prepare | X | X | X |
| **HIV QM TRAINING** -Staff (Recipient Agency) | AETC | | | | | | | | | | | |
| -Staff (Subrecipient Agencies) | AETC | | | | X | X | X | X | X | X | X | X |
| -FXB | | | | | | | | | | | | |
| -FXB Conduct On-Site QI Training (Part B/State) | X | X | X | X | X | X | X | X | X | X | X | X |
| -Consumers | | | | | | | | | | | X | |
| -Professional Clinicians | | | Rutgers FXBC | | | | | | AETC | | | |
| **CONSUMER INPUT & INFRA- STRUCTURE DEVELOPMENT** -Subcommittee | | | | | | | | | X | | | X |
| **QM PROGRAM EVALUATION** | | | | | | | | | | | | Prep QM program eval, present Apr 2021 |

Attachment 2

# NJ DOH HIV PERFORMANCE MEASURES

BIMONTHLY

| | Baseline* April 2020 | Actual Month 2 | Actual Month 4 | Actual Month 6 | Actual Month 8 | Actual Month 10 | Actual Month 12 | Target |
|---|---|---|---|---|---|---|---|---|
| Viral suppression | 86% | 85% | 85% | 86% | 86% | | | 90% |
| Gap | 14% | 13% | 17% | 20% | 20% | | | 10% |
| Medical Visit Frequency | No longer collected due to lack of correlation | | | | | | | 90% |
| ARV Prescribing | 98% | 98% | 98% | 98% | 98% | | | 90% |
| Oral Health Assessment | | | | | | | | 50% |
| Linkage to Care | TBD | | | | | | | 90% |
| Housing Status (Stable) | TBD | | | | | | | 90% |

*Covid-19 lockdown began 3/12/2020. Missed lab work is counted as not virally suppressed by CAREWare. Some agencies had shutdowns as they transferred to telehealth. Some remained open throughout with few patients seen daily to allow for physical distancing and cleaning of facilities in between patients.

ANNUALLY

| | Baseline | Actual Year-end | Target |
|---|---|---|---|
| Medical Case Management (Care Plan)* | | | 90% |
| Mental Health (Depression Care, Screening, Plan) | | | 90% |
| Psychosocial Support | | | 90% |
| Medical Nutrition Therapy | | | 90% |
| Other Services | | | 90% |

| | | | |
|---|---|---|---|
| Medical Transportation | | | 90% |
| Outreach | | | 90% |
| Housing Assistance (Short-Term Emergency) | | | 90% |
| Prison Pre-Discharge Planning | | | 90% |
| Housing | | | 90% |
| Insurance | | | 90% |