

HAB HIV Performance Measures for Adult/Adolescent Clients: Draft for Public Comment



HAB HIV Performance Measures for Adult/Adolescent Clients: ADAP

Performance Measure: ADAP: Application determination		Related OPR Measure: No
Percent of ADAP applications approved or denied for ADAP enrollment within two weeks of ADAP receiving a complete application in the measurement year.		
Numerator:	Number of applications that were approved or denied for ADAP enrollment within two weeks of ADAP receiving a complete application in the measurement year.	
Denominator:	Total number of complete applications received in the measurement year.	
Exclusions:	<ol style="list-style-type: none"> 1. ADAP applications that were incomplete. 2. ADAP applications that were incorrectly filled out. 3. Complete ADAP applications received by ADAP within the last two weeks of the measurement year. 	
Data Element:	<ol style="list-style-type: none"> 1. Did the client apply for ADAP? (Y/N) <ol style="list-style-type: none"> a. If yes, was a determination on the application made by the ADAP program? (Y/N) <ol style="list-style-type: none"> i. If yes, list the date of receipt of the complete application and date of approval or denial. 	
Data Sources:	<ul style="list-style-type: none"> • ADAP Program Data Report 	
National Goals, Targets, or Benchmarks for Comparison:	None available at this time.	
Basis for Selection:		
Timely review for ADAP eligibility can ensure timely access to medications. This quality measure has been used by the Part B and Low Incidence Collaboratives to measure performance and to develop successful improvement projects to decrease the length of time to determine ADAP eligibility or ineligibility by the ADAP program.		
US Public Health Service Guidelines:		
This measure addresses the intent of PHS Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents ¹ .		
References/Notes:		
¹ Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. January 29, 2008; 1-128. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf .		

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**HAB HIV Performance Measures for
Adult/Adolescent Clients: ADAP**

Performance Measure: ADAP: Eligibility recertification		Related OPR Measure: No
Percentage of ADAP enrollees who are reviewed for ADAP eligibility and for Medicaid ineligibility two or more times in the measurement year.		
Numerator:	Number of ADAP enrollees who are reviewed for ADAP eligibility and for Medicaid ineligibility at least two or more times at least three months apart in the measurement year.	
Denominator:	Number of clients enrolled in ADAP program in the measurement year.	
Patient Exclusions:	<ol style="list-style-type: none"> 1. Clients newly enrolled in ADAP in the last six months of measurement year. 2. Clients terminated from ADAP program in the first six months of the measurement year. 	
Data Element:	<ol style="list-style-type: none"> 1. Was the client enrolled in ADAP in the measurement year? (Y/N) <ol style="list-style-type: none"> a. If yes, was the client reviewed for ADAP eligibility and screened for Medicaid ineligibility in the measurement year? (Y/N) <ol style="list-style-type: none"> i. If yes, list the quarters of review. 	
Data Sources:	<ul style="list-style-type: none"> • ADAP Program Data Report 	
National Goals, Targets, or Benchmarks for Comparison:	None available at this time.	
Basis for Selection:		
The Ryan White HIV Treatment Modernization Act of 2006 (P.L. 109-415) ¹ requires that the Ryan White HIV/AIDS Program be the payer of last resort. HAB Policy 07-03 specifies that “grantees must be capable of providing the HAB with documentation related to the use of funds as payer of last resort and the coordination of such funds with other local, State and Federal funds.” ²		
US Public Health Service Guidelines:		
This measure addresses the intent of PHS Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents ³ .		
References/Notes:		
¹ The Ryan White HIV Treatment Modernization Act of 2006 (P.L. 109-415), Section 202(a). ² HRSA/HAB, Policy Notice-07-03, “The Use of Ryan White HIV/AIDS Program, Part B (formerly Title II), AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence and Monitoring Services”, September 2007. ³ Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. January 29, 2008; 1-128. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf .		

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**HAB HIV Performance Measures for
Adult/Adolescent Clients: ADAP**

Performance Measure: ADAP: Formulary		Related OPR Measure: No
Percentage of new anti-retroviral classes that are included in the ADAP formulary within 90 days of the date of inclusion of new anti-retroviral classes in the PHS Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents ¹ during the measurement year.		
Numerator	Number of new anti-retroviral classes included into the ADAP formulary within 90 days of the publication of updated PHS Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents that include new anti-retroviral drug class during the measurement year.	
Denominator:	Total number of new antiretroviral classes published in updated PHS Guidelines during the measurement year.	
Exclusions:	1. PHS Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents published in the last ninety days of the measurement year.	
Data Element:	1. Did the updated PHS Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents include any new anti-retroviral classes? (Y/N) <ol style="list-style-type: none"> a. If yes, (for each new class) was the new class included into the ADAP formulary within 90 days of publication of updated PHS Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents? (Y/N) <ol style="list-style-type: none"> i. If yes, list the date of publication of PHS Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents and date of inclusion in the ADAP formulary. 	
Data Sources:	<ul style="list-style-type: none"> • ADAP quarterly report • ADAP formulary 	
National Goals, Targets, or Benchmarks for Comparison:	100% (Measure is a statutory requirement.)	
Basis for Selection:		
The Ryan White HIV Treatment Modernization Act of 2006 (P.L. 109-415) ² mandates that the state-operated ADAP programs “shall ensure that the therapeutics included on the list of classes of core antiretroviral therapeutics established by the Secretary under subsection (e) are, at a minimum, the treatments provided by the State pursuant to this section”. HRSA/HAB has notified Part B grantees of that all ADAPs must include agents from each of the core antiretroviral classes listed in PHS Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents ³ . These legislative and policy requirements have been specified in the Part B ADAP Grant Application ⁴ .		
US Public Health Service Guidelines:		
US Public Health Service Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents ¹ contains the list of classes of core antiretroviral therapeutics to be included in ADAP formularies.		
References/Notes:		
¹ Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents		

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in HIV-1-infected adults and adolescents. Department of Health and Human Services. January 29, 2008; 1-128. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>

² The Ryan White HIV Treatment Modernization Act of 2006 (P.L. 109-415), Section 202(a).

³ HRSA/HAB, Policy Notice-07-03, "The Use of Ryan White HIV/AIDS Program, Part B (formerly Title II), AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence and Monitoring Services", September 2007.

⁴ Program Guidance: HIV Care Grant Program Part B: States/Territories Formula and Supplemental Awards and AIDS Drug Assistance Program Formula and Supplemental Awards, HRSA Announcement Numbers: *HRSA 08-091*.

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**HAB HIV Performance Measures for
Adult/Adolescent Clients: ADAP**

Performance Measure: ADAP: Inappropriate anti-retroviral regimens or components reviewed and resolved by ADAP		Related OPR Measure: No
Percent of identified inappropriate antiretroviral (ARV) regimen or component prescriptions that are reviewed and resolved by the ADAP program during the measurement year.		
Numerator:	Number of antiretroviral regimen or component prescriptions listed on Table 8 (Antiretroviral Regimens or Components That Should Not Be Offered At Any Time) of the US Public Health Service Guidelines that are reviewed and resolved by the ADAP program during the measurement year.	
Denominator:	Number of inappropriate antiretroviral (ARV) regimen or components that are prescribed and funded by ADAP	
Patient Exclusions:	1. For ADAP clients with multiple sources of funding for their medications, the ADAP program is responsible only for the ARV medications and components funded by ADAP.	
Data Element:	<ol style="list-style-type: none"> 1. Was the prescribed antiretroviral regimen or components paid for by ADAP during the measurement year? (Y/N) <ol style="list-style-type: none"> a. If yes, was the prescribed antiretroviral regimen or components included on Table 8 of the PHS Guidelines¹? (Y/N) <ol style="list-style-type: none"> i. If yes, specify the regimen or components, the prescribing clinician and client. <ol style="list-style-type: none"> 1. If yes, in response to the ADAP program contacting the prescribing clinician, was the ARV regimen or components modified by the prescribing clinician to an ARV regimen or components that is not included on Table 8 or was the ARV regimen or components clinically justified by the prescribing clinician? (Y/N) 	
Data Sources:	<ul style="list-style-type: none"> • Data collected by the ADAP program (ADAP client ID/identifiers, antiretrovirals prescribed, and prescribing clinician) should be systematically reviewed on a routine schedule (i.e., monthly or quarterly) by the ADAP program to identify inappropriate antiretroviral regimen or components. • Clinicians prescribing the identified inappropriate regimens or components should be notified by the ADAP program and the regimen or components reviewed with the ADAP program to determine whether the patient’s treatment should be modified by the prescribing clinician or if the prescribing clinician provides a clinical rationale for an exception (as specified in Table 8). 	
National Goals, Targets, or Benchmarks for Comparison:	None available at this time.	

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Basis for Selection and Placement:

The US Public Health Service Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents specify antiretroviral regimens or components are not generally recommended because of suboptimal antiviral potency, unacceptable toxicities, or pharmacologic concerns.¹ ADAP programs are included as core medical services funded by the Ryan White HIV/AIDS Program, and are therefore, required to provide care and treatment consistent with PHS guidelines. As necessary, the ADAP program should provide clinical consultation and training to clinicians identified through this review process.

US Public Health Service Guidelines:

Antiretroviral Regimens or Components That Should Not Be Offered At Any Time¹

Regimens not recommended	Exceptions
Monotherapy with NRTI	No exceptions except Pregnancy, refer to PHS Guidelines.
Dual therapy with NRTI	No exceptions except Pregnancy and post exposure prophylaxis
Triple therapy with NRTI	Abacavir/Zidovudine/Lamivudine Possibly Tenofovir/Zidovudine/Lamivudine in selected patients
Components not recommended	Exceptions
Atazanavir + Indinavir	NO exceptions
Didanosine + Stavudine	When no other options are available and benefits outweigh risks
Dual NNRTI therapy	Efavirenz + Nevirapine NO exceptions
Efavirenz in first trimester of pregnancy	When no other options are available and benefits outweigh risks
Emtricitabine + Lamivudine	NO exceptions
Stavudine + Zidovudine	NO exceptions
Unboosted Darunavir, Saquinavir or Tipranavir	NO exceptions

References/Notes:

¹ Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. January 29, 2008; 1-128. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>, pp 26-27, 65.

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HAB HIV Performance Measures for Adult/Adolescent Clients: Medical Case Management

Performance Measure: Medical Case Management: Care plan		Related OPR Measure: Yes www.hrsa.gov/performance/performancereview/measures.htm
Percentage of HIV-infected medical case management clients who had a medical case management care plan documented and updated two or more times in the measurement year.		
Numerator:	Number of HIV-infected medical case management clients who had a medical case management care plan documented and updated two or more times at least three months apart in the measurement year.	
Denominator:	Number of HIV-infected medical case management clients who had at least one medical case management encounter in the measurement year.	
Patient Exclusions:	<ol style="list-style-type: none"> 1. Medical case management clients who initiated medical case management services in the last six months of the measurement year. 2. Medical case management clients who were discharged from medical case management services in the last six months of the measurement year. 	
Data Element:	<ol style="list-style-type: none"> 1. Is the client HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, did the client have a medical case management encounter in the measurement year? (Y/N) <ol style="list-style-type: none"> i. If yes, is there a case management plan documented and/or updated two or more times during the measurement year? (Y/N) <ol style="list-style-type: none"> 1. If yes, list the dates of these care plans and/or care plan updates. 	
Data Sources:	<ul style="list-style-type: none"> • Ryan White Data Report (RDR) Section 3, Item 33k may provide useful data regarding the number of clients identified as receiving medical case management. • Electronic databases, such as CAREWare, Provide, ARIES, Lab Tracker, Electronic Medical Record/Electronic Health Record • Case management record* chart abstraction by grantee of a sample of records. 	
National Goals, Targets, or Benchmarks for Comparison:	None available at this time.	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> • Percent of patients who are retained in medical care in the measurement year. • Percent of patients on antiretroviral therapy in the measurement year. 	
Basis for Selection:		
<p>The Ryan White HIV/AIDS Treatment and Modernization Act of 2006 (P.L. 109-415) indicates that medical case management is a core service. Additionally, medical case management services increase access to & retention in medical care.</p> <p>Definition: “Medical Case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. Medical case management services are involved in the coordination and follow-up of medical treatments. These services ensure timely and coordinated access to medically appropriate levels of health and support services and</p>		

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continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.”¹

Case Management is beneficial in dealing with complex needs of people living with HIV/AIDS:

- Reduce cost of care by decreasing hospitalization²
- Clients enrolled in case management are 1.5 times more likely to follow drug regimens³
- Improve chances of newly diagnosed HIV-infected persons entering care³

US Public Health Service Guidelines:

The first principle to success is to negotiate an understandable treatment plan to which the patient can commit [201, 202]. Trusting relationships among the patient, clinician, and health care team (including case managers, social workers, pharmacists, and others) are essential for optimal adherence. Therefore, establishing a trusting relationship over time is critical to good communication that will facilitate quality treatment outcomes. This often requires several office visits and the patience of clinicians, before therapy can be started.

Prior to writing the first prescriptions, clinicians need to assess the patient's readiness to take medication. Patients need to understand that the first regimen is the best chance for long-term success [203]. Resources need to be identified to assist in success. Interventions can also assist with identifying adherence education needs and strategies for each patient. Examples include adherence support groups, adherence counselors, behavioral interventions [204], and using community-based case managers and peer educators.⁴

References/Notes:

* The client's medical record may be used if case management documentation is located in the client's medical record.

¹ “Instructions for Completing the 2007 Ryan White HIV/AIDS Program Data Report”, page 17.

² Cruise, P.L. & Liou, K.T. (1993). AIDS Case management: a study of an innovative health service program in Palm Beach County, Florida. *Journal of Health & Human Resources Administration*, 16, 96-110.

³ Gardner, L.I. Mensch, L.R., Anderson-Mahoney, P., Loughlin, A.M. Et al. Efficacy of a brief case management intervention to link recently diagnosed HIV-infected persons to care. *AIDS* 2005 Mar 4; 19(4): 423-31.

⁴ Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. January 29, 2008; 1-128. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>, page 28.

**HAB HIV Performance Measures for
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**HAB HIV Core Clinical Performance Measures for
Adult/Adolescent Clients: Medical Case Management**

Performance Measure: Medical Case Management: Medical visits		Related OPR Measure: No
Percentage of HIV-infected medical case management clients who had two or more medical visits in an HIV care setting in the measurement year.		
Numerator:	Number of HIV-infected medical case management clients who had a documented medical visit with a provider with prescribing privileges ¹ two or more times at least three months apart in the measurement year.	
Denominator:	Number of HIV-infected medical case management clients who had at least one medical case management encounter in the measurement year.	
Patient Exclusions:	<ol style="list-style-type: none"> 1. Medical case management clients who initiated medical case management services in the last six months of the measurement year. 2. Medical case management clients who were discharged from medical case management services in the last six months of the measurement year. 	
Data Element:	<ol style="list-style-type: none"> 1. Is the client HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, did the client have a medical case management encounter in the measurement year? (Y/N) <ol style="list-style-type: none"> i. If yes, did the medical case manager document that the client had two or more medical visits in an HIV care setting in the measurement year? (Y/N) <ol style="list-style-type: none"> 1. If yes, list the dates of these visits. 	
Data Sources:	<ul style="list-style-type: none"> • Ryan White Data Report (RDR) Section 3, Item 33k may provide useful data regarding the number of clients identified as receiving medical case management. • Electronic databases, such as CAREWare, Provide, ARIES, Lab Tracker, Electronic Medical Record/Electronic Health Record • Case management record* chart abstraction by grantee of a sample of records. 	
National Goals, Targets, or Benchmarks for Comparison	None available at this time.	
Outcome Measures for Consideration	<ul style="list-style-type: none"> • Rate of HIV-related hospitalizations in the measurement year. • Mortality rates. 	
Basis for Selection:		
<p>The Ryan White HIV/AIDS Treatment and Modernization Act of 2006 (P.L. 109-415) indicates that medical case management is a core service. Additionally, medical case management services increase access to & retention in medical care.</p> <p>Definition: “Medical Case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. Medical case management services are involved in the coordination and follow-up of medical treatments. These services ensure timely and coordinated access to medically appropriate levels of health and support services and</p>		

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continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication."²

Case Management is beneficial in dealing with complex needs of people living with HIV/AIDS:

- Reduce cost of care by decreasing hospitalization³
- Clients enrolled in case management are 1.5 times more likely to follow drug regimens⁴
- Improve chances of newly diagnosed HIV-infected persons entering care⁴

US Public Health Service Guidelines:

See HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1, "Medical Visits".⁵

References/Notes:

* The client's medical record may be used if case management documentation is located in the client's medical record.

¹ A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.

² "Instructions for Completing the 2007 Ryan White HIV/AIDS Program Data Report", page 17.

³ Cruise, P.L. & Liou, K.T. (1993). AIDS Case management: a study of an innovative health service program in Palm Beach County, Florida. *Journal of Health & Human Resources Administration*, 16, 96-110.

⁴ Gardner, L.I. Mensch, L.R., Anderson-Mahoney, P., Loughlin, A.M. Et al. Efficacy of a brief case management intervention to link recently diagnosed HIV-infected persons to care. *AIDS* 2005 Mar 4; 19(4): 423-31.

⁵ Available at: <http://hab.hrsa.gov/special/performance/measureMedVisits.htm>.

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**HAB HIV Performance Measures for
Adult/Adolescent Clients: Oral Health Services**

Performance Measure: Oral Health Services: Dental health history	Related OPR Measure: No
Percentage of oral health patients who had a health history* (initial or updated) at least once in the measurement year.	
Numerator:	Number of oral health patients who had a health history* (initial or updated) at least once in the measurement year.
Denominator:	Number of oral health patients that received a comprehensive oral exam (ADA code D0150) or a periodic recall (ADA code D0120) oral evaluation at least once in the measurement year.
Patient Exclusions:	None.
Data Element:	<ol style="list-style-type: none"> 1. Is the client HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, did the client have at least one comprehensive oral exam (ADA code D0150) or a periodic recall (ADA code D0120) oral evaluation once in the measurement year? (Y/N) <ol style="list-style-type: none"> i. If yes, did the client have a health history (initial or updated) in the measurement year? (Y/N) <ol style="list-style-type: none"> 1. If yes, did the health history include: <ol style="list-style-type: none"> (a) Current medications; (b) Appropriate lab values; (c) Name of primary medical care provider; and (d) Review of substance use (e.g., smoking/tobacco, alcohol and drug use).
Data Sources:	<ul style="list-style-type: none"> • The Ryan White Data Report (RDR) Section 3, question 33c (Oral Health Care) can provide data useful in establishing a denominator for this measure. • Electronic Health Record/Electronic Medical Record • Oral health services patient record data abstraction by grantee of a sample of records. • Provider billing systems may be used; however, this will be dependent on the completeness and accuracy of coding of the procedures of interest.
National Goals, Targets, or Benchmarks for Comparison:	None available at this time.
Basis for Selection:	
To develop an appropriate treatment plan, the oral health the care provider should obtain complete information about the patient's health and medication status. Past and present history of tobacco, alcohol and other substance use affect oral health and such information should be collected during the annual health history. ¹	
US Public Health Service Guidelines:	
None.	

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References/Notes:

* The oral health history should include the following components: current medications, appropriate laboratory values, name of primary medical care provider; and review of substance use (e.g., smoking/tobacco, alcohol and drug use).

¹New York State Department of Health. Oral health care for people with HIV infection. New York (NY): New York State Department of Health; 2001 Dec.: 3.

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**HAB HIV Performance Measures for
Adult/Adolescent Clients: Oral Health Services**

Performance Measure: Oral Health Services: Dental treatment plan		Related OPR Measure: No
Percentage of oral health patients who had a documented dental treatment plan in the measurement year.		
Numerator:	Number of oral health patients who had a documented dental treatment plan in the measurement year	
Denominator:	Number of oral health patients that received a comprehensive oral exam (ADA code D0150) or a periodic recall (ADA code D0120) oral evaluation at least once in the measurement year.	
Patient Exclusions:	None.	
Data Element:	<ol style="list-style-type: none"> 1. Is the client HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, did the client have at least one comprehensive oral exam (ADA code D0150) or a periodic recall (ADA code D0120) oral evaluation once in the measurement year? (Y/N) <ol style="list-style-type: none"> i. If yes, did the client have a documented dental treatment plan in the measurement year? (Y/N) 	
Data Sources:	<ul style="list-style-type: none"> • The Ryan White Data Report (RDR) Section 3, question 33c (Oral Health Care) can provide data useful in establishing a denominator for this measure. • Electronic Health Record/Electronic Medical Record • Oral health services patient record data abstraction by grantee of a sample of records. • Provider billing systems may be used; however, this will be dependent on the completeness and accuracy of coding of the procedures of interest. 	
National Goals, Targets, or Benchmarks for Comparison:	None available at this time.	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> • Rate of emergency dental visits in the measurement year. 	
Basis for Selection:		
<p>A comprehensive dental treatment plan that includes preventive care and maintenance should be developed and discussed with the patient. Various treatment options should be discussed and developed in collaboration with the patient. As with all patients, a treatment plan appropriate for the patient's health status, financial status, and individual preference should be chosen.</p> <p>Medications may interfere with dental treatment and cause adverse effects, such as decreased salivary flow, altered liver function, and bone marrow suppression, resulting in anemia, thrombocytopenia, and neutropenia. There is no evidence to support modifications in oral health care based solely on the presence of HIV infection. However, such modifications may be indicated on the basis of certain medical problems that occur</p>		

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as a result of HIV infection. Severely or terminally ill patients, for example, will require alterations in care similar to those of patients suffering from other conditions that cause debilitating illness, such as cancer or mental health impairment.^{1,2}

US Public Health Service Guidelines:

None.

References/Notes:

¹ Glick M, Abel SN, Muzyka BC, DeLorenzo M. Dental complications after treating patients with AIDS. *J Am Dent Assoc* 1994;125:296-301.

² Dental management of the HIV-infected patient. *J Am Dent Assoc* 1995;(Suppl):1-40.

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**HAB HIV Performance Measures for
Adult/Adolescent Clients: Oral Health Services**

Performance Measure: Oral Health Services: Oral health education		Related OPR Measure: No
Percentage of oral health patients who received oral health education* at least once in the measurement year.		
Numerator:	Number of oral health patients who received oral health education* at least once in the measurement year.	
Denominator:	Number of oral health patients that received a comprehensive oral exam (ADA code D0150) or a periodic recall (ADA code D0120) oral evaluation at least once in the measurement year.	
Patient Exclusions:	None	
Data Element:	<ol style="list-style-type: none"> 1. Is the client HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, did the client have at least one comprehensive oral exam (ADA code D0150) or a periodic recall (ADA code D0120) oral evaluation at least once in the measurement year? (Y/N) <ol style="list-style-type: none"> i. If yes, did the client receive oral health education*? (Y/N) <ol style="list-style-type: none"> 1. If yes, did the education include: <ol style="list-style-type: none"> (a) caries prevention (ADA code D1330); and (b) smoking/tobacco cessation counseling (ADA code D1320), if indicated? 	
Data Sources:	<ul style="list-style-type: none"> • The Ryan White Data Report (RDR) Section 3, question 33c (Oral Health Care) can provide data useful in establishing a denominator for this measure. • Electronic Health Record/Electronic Medical Record • Oral health services patient record data abstraction by grantee of a sample of records. • Provider billing systems may be used; however, this will be dependent on the completeness and accuracy of coding of the procedures of interest. 	
National Goals, Targets, or Benchmarks for Comparison:	None available at this time.	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> • Rate of dental disease and oral pathology in the measurement year • Rate of smoking/tobacco cessation in the measurement year. 	
Basis for Selection:		
<p>A higher risk of dental caries in patients with HIV may be caused by decreased salivary flow, which may occur as a result of salivary gland disease or as a side effect of a number of medications. Also, some topical antifungal medications have high sugar content, possibly resulting in increased caries susceptibility. The adverse effects of using tobacco should be discussed with the patients. If patient is a tobacco user, cessation should also be discussed. For in-office consumer and provider materials on tobacco cessation programs, dentists can access http://www.surgeongeneral.gov/tobacco/default.htm.¹</p>		

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US Public Health Service Guidelines:

None.

References/Notes:

* Oral health education should include: caries prevention education (ADA Code D13330) and smoking/tobacco cessation counseling (ADA Code D1320) as indicated. Oral health education may be provided and documented by either a licensed dentist or dental hygienist.
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¹ New York State Department of Health. Oral health care for people with HIV infection. New York (NY): New York State Department of Health; 2001 Dec.: 4.

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**HAB HIV Performance Measures for
Adult/Adolescent Clients: Oral Health Services**

Performance Measure: Oral Health Services: Periodontal examination		Related OPR Measure: No
Percentage of oral health patients who had a periodontal examination* at least once in the measurement year.		
Numerator:	Number of oral health patients who had periodontal exam* (ADA code 0180) at least once in the measurement year	
Denominator:	Number of oral health patients that received a comprehensive oral exam (ADA code D0150) or a periodic recall (ADA code D0120) oral evaluation at least once in the measurement year.	
Patient Exclusions:	1. Patients who received only an emergency exam (ADA code D9110).	
Data Element:	1. Is the client HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, did the client have at least one comprehensive oral exam (ADA code D0150) or a periodic recall (ADA code D0120) oral evaluation at least once in the measurement year? (Y/N) <ol style="list-style-type: none"> i. If yes, did the client have at least one periodontal examination (ADA code 0180) in the measurement year? 	
Data Sources:	<ul style="list-style-type: none"> • The Ryan White Data Report (RDR) Section 3, question 33c (Oral Health Care) can provide data useful in establishing a denominator for this measure. • Electronic Health Record/Electronic Medical Record • Oral health services patient record data abstraction by grantee of a sample of records. • Provider billing systems may be used; however, this will be dependent on the completeness and accuracy of coding of the procedures of interest. 	
National Goals, Targets, or Benchmarks for Comparison:	None available at this time.	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> • Rate of linear gingival erythema (LGE) in the measurement year. • Rate of necrotizing ulcerative periodontitis (NUP) in the measurement year. 	
Basis for Selection:		
<p>Two types of gingival/periodontal disease associated with HIV infection have been widely reported in the literature. In the past, these have been called HIV-associated gingivitis (HIV-G) and HIV-associated periodontitis (HIV-P). There is now evidence that these diseases also occur in HIV negative immunocompromised individuals and are not specific to HIV infection, thus making the original terms inappropriate. Therefore, HIV associated gingivitis has been renamed linear gingival erythema (LGE) and HIV-associated periodontitis has been renamed necrotizing ulcerative periodontitis (NUP).</p> <p>The prevalence of these two diseases remains unclear¹⁻³ with current estimates of occurrence among HIV-infected individuals in the 5-10% range. . There is some evidence that NUP is associated with a low CD4</p>		

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count (<200 cells/mm³).⁴ Early recognition of periodontal problems allows treatment that can prevent progression of these conditions, including severe attachment/bone loss.⁵

US Public Health Service Guidelines:

None.

References/Notes:

* Periodontal examination is the comprehensive evaluation of periodontal condition, probing and charting. When warranted, the Periodontal Screening and Recording (PSR) can also be utilized as a tool to assess the periodontal health status of patients. The periodontal examination may be performed and documented by either a licensed dentist or dental hygienist.

¹ Friedman RB, Gunsolley J, Gentry A. Periodontal status of HIVseropositive and AIDS patients. *J Periodontol* 1991;62:623-627.

² Klein RS, Quart AM, Small CB. Periodontal disease in heterosexuals with acquired immunodeficiency syndrome. *J Periodontol* 1991;62:535-540.

³ Swango P, Kleinman DV, Konzelman JL. HIV and periodontal health: A study of military personnel with HIV. *J Am Dent Assoc* 1991;122:49-52.

⁴ Glick M, Muzyka BD, Salkin LM, Lurie D. Necrotizing ulcerative periodontitis: A marker for immune deterioration and a predictor of the diagnosis of AIDS. *J Periodontol* 1994;65:393-397.

⁵ New York State Department of Health. Oral health care for people with HIV infection. New York (NY): New York State Department of Health; 2001 Dec. 100 p.

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**HAB HIV Performance Measures for
Adult/Adolescent Clients: Oral Health Services**

Performance Measure: Phase 1 dental treatment plan completion		Related OPR Measure: No
Percentage of clients with a Phase 1 dental treatment plan that is completed within 12 months of initiation in the measurement year.		
Numerator:	Number of patients that complete Phase 1 ¹ dental treatment within 12 months of initiating a treatment plan.	
Denominator:	Number of patients with a Phase 1 dental treatment plan begun in the year prior to the measurement year ² .	
Patient Exclusions:	<ul style="list-style-type: none"> Patients who received only an emergency exam (ADA code D9110). 	
Data Element:	<ol style="list-style-type: none"> 1) Is the client HIV-infected? (Y/N) <ol style="list-style-type: none"> a) If yes, did the client have at least one comprehensive oral exam (ADA code D0150) or a periodic recall (ADA code D0120) oral evaluation in the year prior to the measurement year? (Y/N) <ol style="list-style-type: none"> i) If yes, did the client have a Phase 1 dental treatment plan in the year prior to the measurement year? (Y/N) <ol style="list-style-type: none"> 1. If yes, was the Phase 1 dental treatment plan completed within 12 months of initiation? 	
Data Sources:	<ul style="list-style-type: none"> The Ryan White Data Report (RDR) Section 3, question 33c (Oral Health Care) can provide data useful in establishing a denominator for this measure. Electronic Health Record/Electronic Medical Record (A specific “dummy code” to signify when patient treatment is complete can be used to facilitate data collection.) Oral health services patient record data abstraction by grantee of a sample of records. Provider billing systems may be used; however, this will be dependent on the completeness and accuracy of coding of the procedures of interest. 	
National Goals, Targets, or Benchmarks for Comparison:	The goal of the Health Disparities Collaborative for this performance measure is 60%. The BPHC Oral Health Collaborative Pilot is in the planning and testing phase. ³	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> Percent of untreated dental disease and oral pathology in the measurement year 	
Basis for Selection:		
Oral diseases are progressive and cumulative and can affect our ability to eat, the foods we choose, how we look, and the way we communicate. These diseases can affect economic productivity and compromise our ability to work at home, at school, or on the job. Health disparities exist across population groups at all ages. Over one third of the US population (100 million people) has no access to community water fluoridation. Over 108 million children and adults lack dental insurance, which is over 2.5 times the numbers who lack medical insurance. See: US Department of Health and Human Services. <i>Oral Health in America: A Report of the Surgeon General: Executive Summary</i> . Rockville, MD: US Department of Health and Human Services,		

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National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. See: <http://www.surgeongeneral.gov/library/oralhealth>

Community and migrant health center oral health programs seek to increase access to oral health care for the underserved. This performance measure addresses two fundamental areas within community and migrant health center oral health programs: 1) the need to perform a comprehensive oral health exam that culminates with an accompanying treatment plan and 2) assuring that quality care is incorporated in the process of completing needed treatment in a timely manner. The measure facilitates the identification of contributing and restricting factors and practical low cost improvement options relevant to significant areas listed above.

With access to codes associated with comprehensive oral exams and Patient Treatment Completion (PTC), most management information systems will be able to provide an average length of time associated with completion of treatment. With this information, staffing patterns, financial costs (overhead expenses) and efficiency of the oral health program can be assessed. These additional benchmarks could also be measured across health center programs at the local, regional and national levels. The ultimate goal is to measure and assure that health centers routinely and systematically deliver comprehensive, quality oral health services and patient treatment is completed within a reasonable amount of time.

The performance measure is comprehensive in that subsequent performance analysis can broach a number of significant areas, such as: appointment scheduling, ratio of oral health providers to dental operatories, ratio of oral health providers to support staff, collaboration with medical colleagues emphasizing oral health as an essential component of an interdisciplinary approach to patient care, prioritization of patients and/or procedures, general productivity and efficiency.

US Public Health Service Guidelines:

None.

References/Notes:

¹Phase 1 treatment: Prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. This includes: restorative treatment; basic periodontal therapy (non surgical); basic oral surgery that includes simple extractions and biopsy; non-surgical endodontic therapy; and space maintenance and tooth eruption guidance for transitional dentition.

²Patients initiating Phase 1 treatment plan would not be captured in the denominator in the current measurement year. They would, if the care was completed on schedule, be captured in the performance data in the following measurement year.

³ <http://www.healthdisparities.net/hdc/html/collaboratives.topics.prevention.aspx>

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**HAB HIV Performance Measures for
Adult/Adolescent Clients: System Level**

Performance Measure: System Level: Disease status at time of entry into care		Related OPR Measure: No
Percentage of individuals with an AIDS diagnosis at time of initial Ryan White Program-funded primary care medical visit in the measurement year.		
Numerator:	Number of Ryan White Program-funded clients in the system/network meeting the CDC-AIDS diagnostic criteria within 30 days the initial Ryan White Program-funded ambulatory primary medical care visit in the measurement year.	
Denominator:	Number of Ryan White Program-funded clients in the system/network initiating care in the measurement year.	
Patient Exclusions:	1. Patients who previously received primary medical care at another organization.	
Data Element:	1. Did the patient have an initial Ryan White Program-funded primary care visit at this site during the measurement year? (Y/N). <ol style="list-style-type: none"> a. If yes, did the patient meet the CDC AIDS-diagnostic criteria within 30 days of the initial Ryan White Program-funded ambulatory primary care visit? (Y/N) <ol style="list-style-type: none"> i. If yes, list the date of initial visit and date of AIDS diagnosis. 	
Data Sources:	<ul style="list-style-type: none"> • Ryan White Data Report (RDR), Section 2, question 24; Section 3, question 33; and Section 5, questions 45, 46, and 49 • Medical record data abstraction • Electronic databases, such as CAREWare, Lab Tracker, Electronic Medical Record/Electronic Health Record • State surveillance records • Provider client rosters • Client level data (proposed) 	
National Goals, Targets, or Benchmarks for Comparison:	Part C data (historical) indicates 40% of new clients had an AIDS diagnosis.	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> • Rate of opportunistic infections in the measurement year • Rate of HIV-related hospitalizations in the measurement year • Mortality rates 	
Basis for Selection:		
<p>“Patients are presenting later for care than in earlier years, with lower CD4+ cell counts, a small increase of those who have AIDS, and no improvement in time between HIV diagnosis and presentation for care”¹</p> <p>This measure reflects important aspect of care that significantly has an impact on morbidity and mortality; data collection appears to be currently feasible and measure has a strong evidence base for its use across a geographic area.</p>		

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US Public Health Service Guidelines:

Antiretroviral therapy should be initiated in patients with a history of an AIDS-defining illness or with a CD4 T-cell count $<350 \text{ cells/mm}^3$. The data supporting this recommendation are stronger for those with a CD4 T-cell count $<200 \text{ cells/mm}^3$ and with a history of AIDS (AI) than for those with CD4 T-cell counts between 200 and 350 cells/mm³ (AII).

Antiretroviral therapy should also be initiated in the following groups of patients regardless of CD4 T-cell count:

- a. Pregnant women (AI);
- b. Patients with HIV-associated nephropathy (AI); and
- c. Patients coinfectd with HBV when treatment is indicated (BIII).

Antiretroviral therapy may be considered in some patients with CD4 T-cell counts $>350 \text{ cells/mm}^3$.²

References/Notes:

¹ Keruly and Moore, HIV/AIDS CID November 15, 2007, volume 45

² Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. January 29, 2008; 1-128. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>, page 12.

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**HAB HIV Performance Measures for
Adult/Adolescent Clients: System Level**

Performance Measure: System Level: HIV test results for PLWHA		Related OPR Measure: No
Percentage of individuals who test positive for HIV who are given their HIV-antibody test results in the measurement year.		
Numerator:	Number of individuals who are tested by Ryan White Programs in the system/network who test positive for HIV and who are given their HIV antibody test results in the measurement year.	
Denominator:	Number of individuals who are tested by a Ryan White Programs in the system/network and who test positive for HIV in the measurement year.	
Patient Exclusions	<ol style="list-style-type: none"> 1. Patients who test negative for HIV antibodies. 2. Patients who receive an indeterminate HIV antibody test result. 3. Patients who are already aware of their HIV sero-status (i.e., confirmatory test at first medical care visit). 	
Data Element:	<ol style="list-style-type: none"> 1. Was the patient tested for HIV infection at a Ryan White Program-funded organization? (Y/N) <ol style="list-style-type: none"> a. If yes, is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> i. If yes, was the patient given his/her HIV antibody test result? (Y/N) 	
Data Sources:	<ul style="list-style-type: none"> • Ryan White Data Report (RDR), Section 4 Items 38,40 • Electronic databases, such as Lab Tracker, PEMS, Electronic Medical Record/Electronic Health Record 	
National Goals, Targets, or Benchmarks for Comparison:	2006 Ryan White Data Report (RDR) shows that 86% of persons who tested HIV positive were given their test results. The state-wide results ranged from a high of 100% to a low of 49%.	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> • Rate of AIDS diagnosis of patients entering care in the measurement year. • Rate of HIV incidence in the measurement year. 	
Basis for Selection:		
<p>“The U.S. Preventive Services Task Force [in 2005] recommended that clinicians screen for HIV all adults and adolescents at increased risk for HIV, on the basis that when HIV is diagnosed early, appropriately timed interventions, particularly HAART, can lead to improved health outcomes, including slower clinical progression and reduced mortality....Timely access to diagnostic HIV test results also improves health outcomes. Diagnostic testing in health care settings continues to be the mechanism by which nearly half of new HIV infections are identified.... Persons with a diagnosis of HIV infection need a thorough evaluation of their clinical status and immune function to determine their need for antiretroviral treatment or other therapy. HIV-infected persons should receive or be referred for clinical care promptly, consistent with HSPHS guidelines for management of HIV-infected persons.”¹</p>		
US Public Health Service Guidelines:		
<p>“Diagnostic HIV testing and opt-out health screening be a part of routine clinical care in all health-care settings while also preserving the patient’s option to decline HIV testing and ensuring a provider-patient</p>		

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relationship conducive to optimal clinical and preventive care....The central goal of HIV screening in a health-care setting is to maximize the number of persons who are aware of their HIV infection and receive care and prevention services. Definitive mechanisms should be established to inform patients of their test results....HIV-positive test results should be communicated confidentially through personal contact by a clinician, nurse, mid-level practitioner, counselor or other skilled staff...Active efforts are essential to ensure that HIV-infected patients receive their positive tests results and linkages to clinical care, counseling, support, and prevention services”¹

References/Notes:

¹Centers for Disease Control and Prevention. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. MMWR 2006;55 (No. RR-14):1-17

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**HAB HIV Performance Measures for
Adult/Adolescent Clients: System Level**

Performance Measure: System Level: Quality management program		Related OPR Measure: No
Percentage of Ryan White Program-funded clinical organizations with an HIV-specific quality management program in the measurement year.		
Numerator:	Number of Ryan White Program-funded clinical organizations in the system/network with an HIV-specific clinical quality management program in the measurement year.	
Denominator:	Number of Ryan White Program-funded clinical organizations in the system/network in the measurement year.	
Exclusions	None	
Data Element:	1. Is the clinical organization Ryan White Program-funded? (Y/N) a. If yes, did the clinical organization have an HIV-specific clinical quality management program during the measurement year? (Y/N)	
Data Sources:	<ul style="list-style-type: none"> • The Ryan White Program Data Report (RDR) Section 1, question 16; Section 3, question 33, and Section 5, question 54. (Item 33 may be useful in establishing the denominator.) • Ryan White grantee contract language and contract monitoring. • Quality management program documentation. 	
National Goals, Targets, or Benchmarks for Comparison:	100% (Measure is a statutory requirement for Ryan White CARE Act Part A and B grantees.)	
Basis for Selection:		
<p>Quality management requirements were first introduced in 2000 reauthorization of Ryan White CARE Act. Ryan White Treatment and Modernization Act of 2006 (RWTMA) reinforced this requirement. All RWTMA grantees are required to establish clinical quality management programs to:</p> <ul style="list-style-type: none"> • Assess the extent to which HIV health services are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections; and • Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services.¹ <p>A quality management program is defined by HRSA/HAB as: a systematic process with identified leadership, accountability, and dedicated resources and uses data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. Quality management programs should also focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement and be adaptive to change. The process is continuous and should fit within the framework of other programmatic quality assurance and quality improvement activities, such as JCAHO and Medicaid. Data collected as part of this process should be fed back into the quality management process to assure that goals are accomplished and improved outcomes are realized.²</p>		

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US Public Health Service Guidelines:

None.

References/Notes:

¹ Public Law 109-415, Ryan White HIV/AIDS Treatment Modernization Act of 2006, 42 USC 201.

² HRSA/HAB, "HRSA Quality Management Technical Assistance Manual", 2003. Available at: http://hab.hrsa.gov/tools/QM/
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HAB HIV Performance Measures for Adult/Adolescent Clients: System Level

Performance Measure: System Level: Rate of achievement of selected HAB HIV Performance Measure (“Roll up”)	Related OPR Measure: (See corresponding HAB HIV Performance Measures for Adult/Adolescent Clients.*)
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Rate of achievement (percentage of clients) of the performance measurement of interest in the system/network in the measurement year.

Use of Measure:

Grantees that provide systems of care, or that fund multiple organizations or providers to deliver services must look at quality across their system of care. HRSA is providing this performance measure as a guide to rolling a performance measure up from a series of providers & agencies. This will allow the State, City, Consortia or Network to understand the overall performance of a particular performance measure among the funded providers.

This requires appropriate preparation and two different sets of calculations, as outlined below.

Calculation:

Preparation: All providers must use the same measure, and must interpret the inclusion and exclusion criteria exactly the same. The data collection method must yield equivalent results. If data for every client is to be used, then all reporting entities must be able to retrieve and use client level data for that measure. If a sample of patient records is to be used, all reporting entities must use the same sampling method.

There are two sets of calculations that should be done. The first will provide a measure of how well the system of reporting providers is performing this particular quality measure. The second will help to focus efforts for quality improvement, as well as helping to identify best practices. The first calculation will give an average likelihood of a client in the system meeting the performance measure. The second helps examine the likelihood of a client meeting the performance measure in each reporting entity.

First Calculation (Answers the question “How well is the system doing on this measure?”):

- Take the numerator for each reporting entity and add them all together. This is the system numerator.
- Take the denominator for each reporting entity and add them all together. This is the system denominator.
- Calculate the arithmetic mean and express as a percent. This is the system performance measure.

Organization	Agency X	Agency Y	Agency Z	Total
CD4 t-cell count numerator	64	365	924	1353
CD4 T-cell count denominator	76	452	1412	1941
Percent				70%

Second Calculation (Answers the question “How well is Agency X doing on this measure?”):

While the prior measure will give an idea about an “average client,” it may not help determine if this is an

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appropriate area to focus quality improvement efforts. This is because the performance of a larger provider may skew the performance overall within the system. In order to see this, the arithmetic mean and percentage must be calculated for each reporting entity. For instance, Agency X

Organization	Agency X
CD4 t-cell count numerator	64
CD4 T-cell count denominator	76
Percent	84%

System level grantees should use appropriate local groupings as they view the data. For example, if a state provides care at the county level, then measures could be grouped according to county.

Basis for Selection:

Quality management requirements were first introduced in 2000 reauthorization of Ryan White CARE Act. Ryan White Treatment and Modernization Act (RWTMA) reinforced this requirement. All RWTMA grantees are required to establish clinical quality management programs to:

- Assess the extent to which HIV health services are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections; and
- Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services.¹

The HAB HIV Performance Measures “can be used by all programs funded by the Ryan White HIV/AIDS Program and can be used either at the provider or system level. Grantees are encouraged to include the core clinical performance measures in their quality management plans. While data are not required to be submitted to HAB at this time, grantees are strongly encouraged to track and trend data on these measures to monitor the quality of care provided. Grantees are encouraged to identify areas for improvement and to include these in their quality management plans. This type of information can provide rich discussion opportunities with HAB Project Officers.”²

US Public Health Service Guidelines:

See corresponding HAB HIV Performance Measures for Adult/Adolescent Clients.*

References/Notes:

* Systems/network grantees should select from the HRSA HIV performance measures available at: <http://hab.hrsa.gov/special/habmeasures.htm>

¹ Public Law 109-415, Ryan White HIV/AIDS Treatment Modernization Act of 2006, 42 USC 201.

² “Overview of HAB performance measures”, accessed at: <http://hab.hrsa.gov/special/habmeasures.htm> on 18 August 2008.

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**HAB HIV Performance Measures for
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Performance Measure: System Level: Waiting time for initial access to ambulatory primary care		Related OPR Measure: No
Average system-level length of time for a new client to receive an appointment for Ryan White Program-funded ambulatory primary medical care at a specific point in time in the measurement year.		
Numerator:	Sum of the lengths of time for a new Ryan White Program-eligible client to receive an appointment for Ryan White-funded ambulatory primary care reported by service provider organizations in the system/network.	
Denominator:	Number of Ryan-White Program-funded ambulatory primary care provider organizations in the system/network	
Exclusions:	1. Service provider organizations not providing data.	
Data Element:	1. Does the service organization funded by the Ryan-White Program to provide ambulatory primary care? (Y/N) a. If yes, if a new Ryan White Program-eligible client (or his/her agent) were to call to schedule an appointment for ambulatory primary care, in how many days is the third next available appointment for this client?	
Data Sources:	<ul style="list-style-type: none"> Data reported to the system/network grantee at a common point in time by each of the clinical organizations in the system/network that provides ambulatory primary care using a standardized methodology. Data should be reported on a quarterly basis and tracked by the system/network-level grantee. 	
National Goals, Targets, or Benchmarks for Comparison	None available at this time.	
Outcome Measures for Consideration	<ul style="list-style-type: none"> Rate of kept first patient appointments in the measurement year. Rate of PCP in the measurement year. 	
Basis for Selection:		
The Ryan White HIV/AIDS Treatment Modernization Act of 2006 ¹ specifies thirteen core medical services, including outpatient and ambulatory health services, to be funded by the Ryan White HIV/AIDS Program. Improving “access to healthcare is important to the quality of healthcare outcomes. Patients who can promptly schedule appointments with their healthcare providers will have higher satisfaction, will likely return to work sooner, and may well have better medical outcomes.” ²		
US Public Health Service Guidelines:		
None.		
References/Notes:		
¹ Public Law 109-415, Ryan White HIV/AIDS Treatment Modernization Act of 2006, 42 USC 201.		
² National Quality Measures Clearinghouse, “Access: time to third next available appointment for an office		

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visit". Available at: http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?ss=1&doc_id=10912
Further information on this measure is also available at: <http://www.wchq.org/measures/index.php>
(Wisconsin Collaborative for Healthcare Quality).

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