

**HAB HIV CORE CLINICAL PERFORMANCE MEASURES FOR  
ADULTS & ADOLESCENTS: COMPANION GUIDE**  
*APRIL 2009*

This document is intended to explore some of the questions most frequently asked by programs that receive Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) funds. The document focuses on questions related to the *HIV/AIDS AIDS Bureau's (HAB) HIV Core Clinical Performance Measures for Adults & Adolescents: Companion Guide* and will be updated as necessary.

For questions related to broader topics on quality management and the Ryan White HIV/AIDS Program, please refer to *Developing an Effective Quality Management Program in Accordance with the Ryan White HIV/AIDS Treatment Modernization Act of 2006: Frequently Asked Questions* available at: <http://www.ihl.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Tools/FAQonDevelopinganEffectiveQMProgram.htm>.

The following questions have been frequently asked and the corresponding answers are detailed in this document:

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## **Scope of HAB Core Clinical Performance Measures**

*Question: Are the core clinical performance measures applicable to all Parts?*

Answer: Yes, the HAB PMs can be used by all programs funded by the Ryan White HIV/AIDS Program that provide HIV care or other relevant services. The measures can be used either at the provider or system level. The measures can be rolled up to look at issues from a system perspective, such as with Part A and B Programs. Programs can also work with their subcontractors, vendors or subgrantees to implement the performance measures at the provider level. Grantees are encouraged to include the core clinical performance measures in their quality management plan.

*Question: How are these performance measures different from ones previously released by HAB?*

Answer: In April 2007, a draft set of performance measures were released for public comment. Based on the tremendous feedback received, the performance measures were revised to address many of the issues raised. From this point forward, the measures will be reviewed on an annual basis and revised as necessary.

*Question: Does this mean that HAB considers these measures the really important ones?*

Answer: HAB considers all of the clinical performance measures that were released in April 2007 critical to good care. The measures were released in phases to allow for staged implementation. If a clinical program has no performance measures, Group 1 measures provide an excellent start and can serve as a foundation on which to build. Group 2 measures are important measures for a robust clinical management program and should be seriously considered. Group 3 measures represent areas of care that represent best practice, but may be difficult to collect data or lack written clinical guidelines.

*Question: Are children included in the eligible population?*

Answer: No. Children aged 12 years and younger are not included in the HAB core performance measures. A separate set of measures targeted to children will be developed in 2009.

*Question: Why aren't general health indicators included in the HAB core performance measures?*

Answer: National performance measures have been established for a wide range of general health conditions, such as immunizations, prenatal care and screenings. Since there are currently no national consensus performance measures for HIV care, the HAB HIV Core Clinical Performance Measures focus on key elements of care that are unique to the HIV-infected patient population served by the Ryan White HIV/AIDS Programs.

*Question: Why isn't ophthalmology screening included in HAB's list of measures?*

Answer: Ophthalmology screening was removed from HAB's list of measures as a result of several factors. The primary method for preventing severe cytomegalovirus (CMV) disease is recognition of early manifestations of the disease. Current guidelines<sup>1</sup> recommend patients being made aware of the importance of increased floaters in the eye and advising them to assess their visual acuity regularly by using simple techniques, such as reading newsprint. This recommendation is considered a "BIII" recommendation.<sup>2</sup> Regular fundoscopic examinations performed by an ophthalmologist are recommended by certain specialists for patients with low (e.g., <50 cells/ $\mu$ L) CD4+ counts and is considered a "CIII" recommendation. Annual screening would not be sufficient to detect CMV retinitis as it invariably progresses, usually within 10-21 days after presentation in the absence of ART or anti-CMV therapy. The lack of clinical evidence, frequency of screening and cost all contributed to the removal of ophthalmology screening from HAB's performance measures.

*Question: Why isn't basic patient education included in HAB's list of measures?*

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<sup>1</sup> Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. June 18, 2008; 1-134.

([http://aidsinfo.nih.gov/contentfiles/Adult\\_OI.pdf](http://aidsinfo.nih.gov/contentfiles/Adult_OI.pdf))

<sup>2</sup> The PHS guidelines rate the strength of recommendations (A-E) and the quality of evidence (I-III). An "A" rating indicates a strong recommendation while an "E" should never be offered. An "I" ranking includes randomized trials with either clinical or validated laboratory outcomes, e.g. viral load. An "III" rating is a recommendation based on expert opinion.

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**Answer:** A significant amount of feedback was received in regards to the measure related to general patient education and the similarity to other measures. Patient education is clearly an important element of care that should be integrated into every visit. Patient education permeates the other HAB measures and became redundant with this single measure. As a result, it was removed from the list of measures.

**Question:** *Why is Hepatitis B screening and vaccination presented as two separate measures?*

**Answer:** Hepatitis B screening and vaccination are important for different reasons. HBV is the leading cause of chronic liver disease worldwide with up to 90% of HIV-infected persons having at least one serum marker. For those infected with HBV, flares in HBV activity can lead to liver-associated complications. In addition, toxicity to ARV therapy can affect the treatment of HIV in coinfecting patients. By knowing the patient's HBV status, both diseases can be managed more effectively. For those who are not infected with HBV, vaccination can prevent transmission. Additional information related to hepatitis can be found at [www.cdc.gov/hepatitis/HBV.htm](http://www.cdc.gov/hepatitis/HBV.htm).

**Question:** *Why isn't Hepatitis A vaccination included in HAB's list of measures?*

**Answer:** Hepatitis A vaccination was removed from HAB's list of measures because it is not uniformly recommended for all populations. According to the CDC guidelines<sup>3</sup>, Hepatitis A vaccination is recommended in persons with chronic liver disease, men who have sex with men and injection drug users. HAV-susceptible, HIV-infected individuals with risk factors for HAV infection should also receive hepatitis A vaccination. The complexity of identifying the population focus limited the utility of the measure. Combined with other measures that address similar topics, such as HBV screening, HBV vaccination, HCV screening and other

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<sup>3</sup> Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. June 18, 2008; 1-134. ([http://aidsinfo.nih.gov/contentfiles/Adult\\_OI.pdf](http://aidsinfo.nih.gov/contentfiles/Adult_OI.pdf))

immunizations, HAB elected to remove Hepatitis A vaccination from the core group of clinical indicators.

*Question: Why aren't performance measures for case management or other supportive services included in the HAB core clinical performance measures?*

Answer: Because these measures focus on medical care, measures for case management and other supportive services have not been included. Separate performance measures were released for public comment in Fall 2008 related to case management, oral health, AIDS Drug Assistance Program (ADAP) and systems of care. These measures are anticipated to be released in their final form in summer 2009.

*Question: What is the difference between a performance measure and standard of care?*

Answer: A performance measure provides an indication of an organization's performance in relation to a specified process or outcome. Standards of care are guidelines that outline the expectations of care around a specific issue or topic and are created by a group of subject matter or clinical experts. Because performance measures and standards of care each serve a different purpose, they are not always in accordance. For instance, with the Medical Visit performance measure, the standard of care states that routine monitoring should occur at least every three to four months depending on the stage of disease. For the purpose of the performance measure, the time frame of six months was determined by clinical expert consensus to allow for those patients that are well controlled clinically and stable on their current regimen. Per the guidelines, patients can and should be seen at more frequent intervals as dictated by their current health status.

*Question: Will data be used for punitive purposes?*

Answer: As a general rule of thumb, data for quality improvement purposes are not designed to be punitive or used to consider funding levels/decisions. Quality improvement data should be used to document areas of strength, identify areas for improvement and help guide, shape and enhance the delivery and quality of care. The intent is to minimize wide fluctuations in care and maintain a consistent level of service.

## Elements of HAB Core Performance Measures

*Question: OPR measures are referenced in the upper right hand corner of the performance measure table. What does this refer to?*

Answer: HRSA's Office of Performance Review (OPR) conducts site visits (performance reviews) to programs that receive funding from HRSA. As part of the site visit, a few performance measures are selected and used during the process. Some of the OPR measures are similar or the same as HAB's clinical performance measures. In those instances, "OPR-Related Measure: Yes" is referenced in the upper right hand corner of the table. "OPR-Related Measure: No" indicates there is not a corresponding measure. Additional information about the OPR site visit process and list of performance measures can be located at: <http://www.hrsa.gov/performance-review/>.

*Question: What are patient exclusions?*

Answer: For each performance measure an eligible population must be determined. Depending on the element of care being measured, certain patients should be excluded from the denominator in order to gather accurate data. For instance, in the HAART measure, patients seen for the first time in the last three (3) months of the measurement year will be excluded because a provider generally needs at least two (2) visits to evaluate the patient prior to prescribing HAART. Once the exclusions are applied and the population defined, the data elements are used to collect information on the performance measure.

*Question: Why isn't exclusion criteria similar to PCP prophylaxis included in the MAC prophylaxis measure?*

Answer: Exclusion criteria are included if a specific issue or event has the potential to significantly impact the data and results. Based on the small number of patients affected by MAC and the smaller subset of patients whose CD4 count rises above 50 cells/mm<sup>3</sup> after being repeated three months later, it was determined that exclusion criteria for this situation was not warranted. If, after analyzing the data, this is determined to be a more prevalent issue for your program, grantees may choose to utilize the following exclusion criteria:

- Patients with CD4 T-cell counts below 50 cells/mm<sup>3</sup> repeated within 3 months rose above 50 cells/mm<sup>3</sup>

*Question: Data are presented on national goals, targets and benchmarks. How are these to be used?*

Answer: First and foremost it is important to understand that the data reflect similar, but not the exact performance measure. They may vary in purpose or definition. The similarities do, however, provide an opportunity to compare performance from your organization to the performance of other Ryan White programs. For instance, an IHI goal for cervical cancer screening was set for 90% and data for the National HIVQUAL Project show the median at 73.7%, with sites performing in the top 10% reaching 100%. If your program is struggling with a completion rate of 34%, using the comparative data highlights potential disparity between your site and other programs. This type of information can then be used to set realistic goals and priorities for quality improvement projects.

*Question: Why have outcome measures been added to the performance measures?*

Answer: During the comment period many respondents requested specific outcome measures identified as a way to move their quality management programs along. By including the section "Outcome Measures for Consideration", HAB is providing direction on potential areas of focus.

*Question: What constitutes an HIV care setting?*

Answer: For the purposes of these measures, an HIV care setting is one which receives Ryan White HIV/AIDS Treatment Modernization Act of 2006 funding to provide HIV care. Each program receiving these funds is required to implement a quality management program to monitor the quality of care and address needs as appropriate.

*Question: What constitutes a medical visit?*

Answer: For the purposes of these measures, a medical visit is considered any visit with a health care professional who is certified in their jurisdiction and has prescribing privileges.

*Question: Can a lab test be used as a surrogate marker for medical visit?*

Answer: Because lab tests do not have to coincide with a medical visit to a provider with prescribing privileges, a lab test can not be used as a surrogate marker for a medical visit.

*Question: Can a phone consultation be counted as a medical visit?*

Answer: No, a phone consultation can not be counted as a medical visit.

*Question: What is meant by "HAART"?*

Answer: HAART stands for "highly active antiretroviral therapy" and refers to combination antiretroviral therapy that is of sufficient potency to achieve an undetectable viral load in most all cases. Guidelines on HAART can be found at <http://www.aidsinfo.nih.gov/>.

*Question: Why do the performance measures focus on prescribing a treatment rather than offering it to the client? This does not take the patient's right to refuse treatment into consideration.*

Answer: It is understood that patients, for many reasons, may choose not to fill or take a prescribed treatment and it is not expected that programs will have attained 100% compliance on the measures. However, it is important for programs to capture the actual percentage of clients that are on a prescribed treatment regimen and identify opportunities for improvement. Often times when programs begin to track and trend data, they find unexpected levels of performance and new opportunities for improvement.

*Question: Patients often refuse vaccinations. Why isn't patient refusal considered as an exclusion criteria?*

Answer: As with other treatment regimens, some clients will refuse vaccinations. However, clinical data have shown immunizations to be a critical component of care in respect to prevention, care and treatment. It is important for programs to know the degree to which vaccinations, or other standards of care, are being refused. If high rates of refusal are noted this should be further examined as a quality issue. For example, data could be reviewed to

identify trends in client refusal, such as patient demographics, geographic distance, stage of illness, etc. Key informant interviews can also provide additional information in regards to reasons for refusal.

*Question: Why isn't CD4+ percentage included as a point of PCP prophylaxis initiation?*

Answer: For HIV care, CD4+ percentage is routinely used to monitor children age 12 years and younger. A separate set of clinical performance measures will be developed for the pediatric population.

*Question: What constitutes adherence assessment and counseling and who can provide it?*

Answer: Adherence assessment and counseling occur in the context of comprehensive medical care. Anyone on the care team can conduct the assessment or provide counseling as long as appropriate feedback is given to the provider so that treatment changes can be made as necessary. Sessions provided as part of the medical visit can be counted and do not require a separate visit. Assessment of adherence can include patient reports through the use of quantifiable scales, such as missing 9 out of 10 doses, or through qualitative Likert scales which rate a response based on a numeric scale, e.g. 1-5. Assessment can also be made through quantified reviews such as pill counts or pharmacy dispensing records.

*Question: What constitutes risk counseling and who can provide it?*

Answer: Risk counseling includes the assessment of risk, provision of counseling and as necessary, referrals to appropriate resources. As with adherence assessment and counseling, risk counseling occurs in the context of comprehensive medical care. Anyone on the care team can provide the counseling as long as appropriate feedback is given to the provider so that the treatment plan and approach can be modified as necessary. Sessions provided as part of the medical visit can be counted and do not require a separate visit.

*Question: If a woman has had a hysterectomy, should she be screened for cervical cancer?*

Answer: The answer depends on the reason for the hysterectomy. If the hysterectomy was performed for non-dysplasia or non-malignant conditions, then a Pap screen does not need to be completed. In these instances, the client would be excluded from the denominator. If, however, the hysterectomy was performed because of dysplasia or cancer, Pap screens should be completed and the client should be included in the denominator.

*Question: If a patient has undergone male-to-female transgender surgery, should she be screened for cervical cancer?*

Answer: If the glans penis was used to construct the cervix then Pap screens should be completed according to the same schedule recommended for all women.

*Question: Does Medicare cover fasting lipid panels?*

Answer: There are different rules of coverage, depending on the situation of the patient.

1) *Lipid evaluation as a screening test:* A patient entitled to Medicare Part B may receive coverage of screening blood tests for the early detection of cardiovascular disease in individuals without signs or symptoms of heart disease and stroke. This Medicare cardiovascular screening benefit includes coverage of the use of three screening blood tests, a total cholesterol, a HDL, cholesterol, and a triglycerides tests (performed after a 12-hour fasting period) ordered individually or together as a lipid panel (CPT code 80061). Frequency of coverage is limited to either each individual test or 1 lipid panel every 5 years. If any abnormal value is obtained in performing these screening tests, further testing may be covered under the diagnostic clinical laboratory benefit, if it is ordered by the patient's physician and the local Medicare contractor determines that it is medically necessary for the patient in accordance with the coverage policy on lipid testing as described in section 190.23 of the Medicare National Coverage Determinations (NCD) Manual.

2) *Lipid evaluation to assess for lipid perturbations caused by antiretroviral agents:* If the patient is prescribed a medication that may cause lipid perturbations, such as occurs with some

antiretroviral agents, the lipid test is not a true “screening” test, but a diagnostic test. In this setting, a lipid panel (CPT code 80061) may be covered by Medicare if the diagnostic code of 272.6 (Lipodystrophy) or V58.69 (Long term [current] use of other medicines) is applicable and used for that visit and the local Medicare contractor determines that such coverage is consistent with the coverage policy on lipid testing as described in section 190.23 of the Medicare NCD Manual.

*Question: For Hepatitis B vaccination are the numerator and denominator measuring two different populations? Why are new patients excluded?*

Answer: The measure is designed to capture the percentage of clients who completed the vaccination series, which represents a 3-dose schedule. The denominator represents those clients who were seen in the measurement year and had no documentation of ever having vaccination or documented susceptibility to Hepatitis B. Comparing those who were eligible for the vaccination series (denominator) with those who received the series (numerator), the percentage can be calculated. Clients new to care in the measurement year may have begun the series, but may not have completed the entire course within the defined time period.

*Question: Hepatitis B vaccination is a one-time series for immunization. How will this be monitored over time?*

Answer: At the client level, it is important to determine if the client was eligible and had received Hepatitis B vaccination at one point during the client’s life. When looking at data over time, the focal point shifts and concentrates on completion rates of the vaccination series for the clinic population as a whole. If the rates of completion are lower than desired, specific points of influence can be explored to have a positive impact and raise the rates. Potential points of influence (or areas for improvement) can be related to the process of notifying the provider of an impending vaccine, reminding clients of appointments to receive the vaccination or patient education about the need and importance of the vaccination. Any one of these areas could have a positive impact on the completion rates of vaccination series.

*Question: In regards to Hepatitis B immunization, should patients with isolated anti-HBc be included or excluded in the denominator?*

Answer: In certain persons, the only HBV serologic marker detected in serum is anti-HBc and may not be detectable by commercial serology<sup>4</sup>. Therefore, including or excluding patients with isolated anti-HBc depends on the rate of prevalence of Hepatitis B in the clinic population. Some experts recommend persons who are positive only for anti-HBc and who are from a low endemic area with no risk factors for HBV should be given the full series of Hepatitis B vaccine<sup>5</sup>. Re-evaluation is recommended if there is no response after vaccination. Additional information can be found at:  
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5516a1.htm>

*Question: Dental care is not readily available in many communities. Why is this included as a core clinical performance measure?*

Answer: Aggregate data presented by the National HIVQUAL Project indicates approximately one-third of clients receive an annual dental screening<sup>6</sup>. While many primary care providers are not in a position to assure dental care is available, oral exams performed by a dentist remains a critical part of primary care. It is important to establish the baseline frequency of services being rendered and as a result, have been included in the core clinical performance measures. Such data may help document gaps in care.

*Question: What is the difference between an oral exam and dental screening? Can the oral exam be completed by a physician?*

Answer: A dental screening can be performed by any trained health care professional and is used to determine whether dental services are required. An oral exam includes a comprehensive examination of hard and soft tissues in the oral cavity and must be completed by a dentist. The focus of this measure is to determine the percentage of clients who receive an annual oral exam, and therefore, must be completed by a dentist. For purposes of this measure,

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<sup>4</sup> Centers for Disease Control and Prevention. A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States; Recommendations of the Advisory Committee on Immunization Practices (ACIP) Part II: Immunization of Adults. MMWR 2006;55(No. RR-16):

<sup>5</sup> Lok AS, McMahon BJ. Chronic hepatitis B. Hepatology 2007 Feb;45(2):507-39.

<sup>6</sup> <http://www.hivguidelines.org/admin/files/goc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>

documentation may be based on patient self report or other documentation.

*Question: Since toxoplasmosis affects only those clients with CD4 counts < 50 cells/mm<sup>3</sup>, why does it apply to all clients?*

Answer: While it is true that clients with CD4 counts <50 cells/mm<sup>3</sup> are at greatest risk for developing toxoplasmic disease, the measure focuses on the identification of latent infection, not to prevent illness. Current guidelines<sup>7</sup> recommend all HIV-infected persons be tested for IgG antibody to *Toxoplasma* soon after the diagnosis of HIV infection and counseled regarding sources of *Toxoplasma* infection.

*Question: Why is urogenital testing the only testing referenced in the chlamydia and gonorrhea measures?*

Answer: CDC guidelines<sup>8</sup> recommend considering testing for urogenital chlamydial infection and urogenital gonorrhea on the first visit for all patients. Appropriate medical care would require testing of other sites based on the specific risks. For instance, patients reporting receptive oral sex should be tested for pharyngeal gonococcal infection. Readers are encouraged to review the CDC guidelines to determine the most appropriate testing for their population ([http://aidsinfo.nih.gov/contentfiles/HIVPreventionInMedCare\\_TB.pdf](http://aidsinfo.nih.gov/contentfiles/HIVPreventionInMedCare_TB.pdf)).

*Question: Why does the substance use measure only focus on newly enrolled clients?*

Answer: The purpose of screening newly enrolled clients is to identify past or current problems with substance use that can negatively impact linkage to care and management of their disease. The measure hones in on this aspect of care knowing that additional assistance may be required to effectively link this population to care. This does not imply established clients should not be screened. As part

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<sup>7</sup> Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-infected Adults & Adolescents. June 18, 2008; 1-134.  
[http://aidsinfo.nih.gov/contentfile/Adult\\_OI.pdf](http://aidsinfo.nih.gov/contentfile/Adult_OI.pdf).

<sup>8</sup> Incorporating HIV Prevention into the Medical Care of Persons Living with HIV (2003).  
[http://aidsinfo.nih.gov/contentfiles/HIVPreventionInMedCare\\_TB.pdf](http://aidsinfo.nih.gov/contentfiles/HIVPreventionInMedCare_TB.pdf)

of their ongoing care, all clients should be screened annually for substance use.

*Question: Many of the measures reflect aspects of care that require referrals, yet the measures do not address this. Are we expected to follow-up?*

Answer: Very few organizations can provide the full range of services needed by our clients. By default, referrals become a necessary part of the continuum of care. As such, it is important that an organization be able to monitor, track and document the outcome of referrals to ensure the care requirements are being met for each client. Tracking of referrals should be integrated into the system of care and policies and procedures should outline the expectations of the referring agency.

## Data Collection & Reporting

*Question: Are Ryan White HIV/AIDS Program grantees required to submit data to HAB on the defined performance measures?*

Answer: The performance measures represent key clinical decision points and should be included as part of a quality management program for those providing services to the HIV-infected population. 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 plan. This type of information provides rich discussion opportunities with their Project Officers.

In addition, the HIV/AIDS Bureau is pursuing the development of client level data reporting for Ryan White HIV/AIDS Program grantees. Certain data elements deemed critical for client level data reporting purposes may correspond to the core clinical performance measures. In these instances, efforts to align the data elements are being undertaken.

**HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Companion Guide**



*Question: Does CAREWare tabulate data for HAB's clinical performance measures?*

Answer: Within CAREWare the Performance Measurement Module (PMM) has been created and is available for use. The PMM allows the user to enter and tabulate data for HAB's Group 1 and Group 2 measures. If the feature is beneficial to users, additional measures may be added at a later point. It is also important to know that CAREWare allows the user to customize performance measures. Therefore, any of HAB's measures can be added or new measures can be created.

*Question: What is the measurement year and can it be altered?*

Answer: The measurement year is the calendar year and yes, it can be altered to match your organization's performance measurement cycle. It was delineated as a calendar year to coincide with client level data.

*Question: Why isn't the standard measurement year used for influenza vaccination ?*

Answer: Influenza vaccines are administered during the cold and flu season, typically September through February. If a standard calendar year was used with this measure, some clients may receive two vaccines in a given year, but for two different flu seasons. For instance, a client may receive the vaccine for 2007-2008 flu season in January 2008 (see table below). A second vaccine can be given in November 2008 for the 2008-2009 flu season. If the client does not receive the vaccine for the 2009-2010 flu season until January 2010, they would not count in the 2009 data reviews if a calendar year was used. By changing the measurement period to April-March, all clients would be included.

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2008	x										x	
2009												
2010	x											

*Question: Can client self-report be used?*

Answer: In general, client self-report has been determined to be fairly unreliable. Of the performance measures released in Groups 1-3, only one measure, oral exam, allows for client self-report.

*Question: Is the denominator, for the measures reflecting data available statewide through surveillance (such as number of CD4+ tests and test values), only clients served by a Ryan White HIV/AIDS Program-funded service (seen in the reporting year) or may we report on all known, living PLWH/A in the aggregate?*

Answer: For the purposes of these measures, the denominator should include only those clients served by Ryan White HIV/AIDS Program-funded providers.

## Resource Materials & Feedback

*Question: Have any chart review tools been created that are specific to the HAB core clinical performance measures?*

Answer: Sample chart review tools are currently being developed. Once they have been tested and finalized, the tools will be posted on the HAB website (<http://hab.hrsa.gov>), TARGET Center (<http://careacttarget.org/>) and the National Quality Center ([www.nationalqualitycenter.org](http://www.nationalqualitycenter.org)).

*Question: Where can I get more information about the HAB core clinical performance measures?*

Answer: Additional questions related to the core clinical performance measures can be posed to the TARGET Center HELPDESK at 301/443-0067, the National Quality Center at 888/672-7482 or to your Project Officer.

*Question: Where can I get more information about quality improvement?*

Answer: Each industry and field of service has its own definitions of quality management, quality assurance, and quality improvement. Keeping with the spirit of the Ryan White HIV/AIDS Program's commitment to quality, The Ryan White HIV/AIDS Program legislation has clearly

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defined quality management expectations, and HRSA/HAB has produced several technical assistance QI publications and training modules to highlight examples from other grantees. Many resources are available at the HRSA's HIV/AIDS Bureau website [[hab.hrsa.gov](http://hab.hrsa.gov)].

Other resources include the National Quality Center [[www.NationalQualityCenter.org](http://www.NationalQualityCenter.org)], the National HIVQUAL Project [[www.HIVQUAL.org](http://www.HIVQUAL.org)], both administered by the New York State Department of Health AIDS Institute, and the Institute for Healthcare Improvement [[www.IHI.org](http://www.IHI.org)].

*Question: How can I provide feedback on HAB's core clinical performance measures?*

Answer: HAB is extremely interested in receiving feedback regarding the core clinical performance measures, particularly as it relates to the use of the measures. If you have any information you would like to share in regards to the utility, suggestions for improvement or examples of how the information has been used, please send an e-mail to [HIVmeasures@hrsa.gov](mailto:HIVmeasures@hrsa.gov).