

HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 3



Performance Measure: Chlamydia Screening		OPR-Related Measure: No
Percentage of clients ¹ with HIV infection at risk for sexually transmitted infections (STI) who had a test for chlamydia within the measurement year		
Numerator:	Number of HIV-infected clients who had a test for chlamydia	
Denominator:	Number of HIV-infected clients who: <ul style="list-style-type: none"> • were either: a) newly enrolled in care; b) sexually active; or c) had a STI within the last 12 months, and • had a medical visit with a provider with prescribing privileges² at least once in the measurement year 	
Patient Exclusions:	1. Patients who were < 18 years old ³ and denied a history of sexual activity	
Data Elements:	1. Is the client HIV-infected? (Y/N) <ul style="list-style-type: none"> a. If yes, is the client new to care, sexually active or had a STI within the last 12 months? (Y/N) <ul style="list-style-type: none"> i. If yes, was the client tested for chlamydia during the measurement year? (Y/N) 	
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker or other electronic data base • Medical record data abstraction by grantee of a sample of records • Billing records 	
National Goals, Targets, or Benchmarks for Comparison:	None available at this time	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> • Incidence of STIs in the clinic population • Incidence of pelvic inflammatory disease in the clinic population 	
Basis for Selection and Placement in Group 3:		
<p>Early detection and treatment of STIs may reduce the risk for STI and HIV transmission. Providers should screen for STIs to treat infections and decrease HIV transmission to sexual partners. Many STIs increase the number of HIV-infected white blood cells in the genital area and increase the risk of transmitting HIV infection.⁴ STIs can also enhance the risk of transmitting HIV by increasing the viral burden in genital secretions.^{5,6}</p> <p>STIs in seronegative partners increase the risk for acquiring HIV because they increase the volume of white blood cells, including those that are targeted by HIV, in the genital region, and may cause ulcerative lesions, increasing the likelihood of infection.⁷ Susceptibility to transmission may therefore be enhanced.</p> <p>Chlamydia infection in women may often be asymptomatic but like other STIs can also increase the risk for</p>		

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HIV transmission and enhance transmission susceptibility. Providers should test women for cervical chlamydial infection at least annually to treat infections and to decrease the risk of chlamydia and HIV transmission.

Identification and treatment of STIs can reduce the potential for spread of these infections among high-risk groups (i.e., sex or drug-using networks).⁸

The measure was placed in Group 3 because it focuses on similar aspects of care (STI marker) previously captured in measures included in Groups 1 & 2. There are currently no guidelines that delineate routine annual testing for chlamydia.

US Public Health Guidelines:

“During the first visit, consider testing all patients for urogenital chlamydial infection. For subsequent routine visits, repeat tests periodically (i.e. at least annually) for all patients who are sexually active. More frequent periodic screening (e.g. at 3-month to 6-month intervals) may be indicated for asymptomatic persons at higher risk. Presence of any of the following factors may support more frequent than annual periodic screening: 1) multiple or anonymous sex partners; 2) past history of any STD; 3) identification of other behaviors associated with transmission of HIV and other STDs; 4) sex or needle-sharing partner(s) with any of the above-mentioned risks; 5) developmental changes in life that may lead to behavioral change with increased risky behaviors; or 6) high prevalence of STDs in the area or in the patient population.”⁹

References/Notes:

¹ “Clients” includes all clients aged 13 years and older.

² A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe medications.

³ Onset of sexual activity is not reliably reported or recorded. The lower age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur.

⁴ Cohen MS. Sexually transmitted diseases enhance HIV transmission: no longer a hypothesis. *Lancet* 1998;351(suppl 3):5-7.

⁵ Buchacz K, Patel P, Taylor M, et al. Syphilis increases HIV viral load and decreases CD4 cell counts in HIV-infected patients with new syphilis infections. *AIDS*. 2004 Oct 21;18(15):2075-9.

⁶ CDC. Recommendations and Reports: “Incorporating HIV Prevention into the Medical Care of Persons Living with HIV”. July 18, 2003/52(RR12);1-24.

⁷ DT Fleming and JN Wasserheit, From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection, *Sex Transm Infect* 75 (1999), pp. 3–17.

⁸ CDC. Recommendations and Reports: “Incorporating HIV Prevention into the Medical Care of Persons Living with HIV”. July 18, 2003/52(RR12);1-24.

⁹ Ibid.

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Performance Measure: Gonorrhea Screening		OPR-Related Measure: No
Percentage of clients ¹ with HIV infection at risk for sexually transmitted infections (STIs) who had a test for gonorrhea within the measurement year		
Numerator:	Number of HIV-infected clients who had a test for gonorrhea	
Denominator:	Number of HIV-infected clients who: <ul style="list-style-type: none"> • were either: a) newly enrolled in care; b) sexually active; or c) had a STI within the last 12 months; and • had a medical visit with a provider with prescribing privileges² at least once in the measurement year 	
Patient Exclusions:	1. Patients who were \leq 18 years old ³ and denied a history of sexual activity	
Data Elements:	1. Is the client HIV-infected? (Y/N) <ol style="list-style-type: none"> If yes, is the client new to care, sexually active or had a STI within the last 12 months? (Y/N) <ol style="list-style-type: none"> If yes, was the client tested for gonorrhea during the measurement year? (Y/N) 	
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker or other electronic data base • Medical record data abstraction by grantee of a sample of records • Billing records 	
National Goals, Targets, or Benchmarks for Comparison:	None available at this time	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> • Incidence of STIs in the clinic population 	
Basis for Selection and Placement in Group 3:		
<p>Early detection and treatment of STIs may reduce the risk for STD and HIV transmission. Providers should screen for STIs to treat infections and decrease HIV transmission to sexual partners. Many STIs increase the number of HIV-infected white blood cells in the genital area and increase the risk of transmitting HIV infection.⁴ STIs can also enhance the risk of transmitting HIV by increasing the viral burden in genital secretions.⁵</p> <p>STIs in seronegative partners increase the risk for acquiring HIV because they increase the volume of white blood cells, including those that are targeted by HIV, in the genital region, and may cause ulcerative lesions, increasing the likelihood of infection.⁶ Susceptibility to transmission may therefore be enhanced.</p>		

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Identification and treatment of STIs can reduce the potential for spread of these infections among high-risk groups (i.e., sex or drug-using networks).⁷

The measure was placed in Group 3 because it focuses on similar aspects of care (STI marker) previously captured in measures included in Groups 1 & 2. There are currently no guidelines that delineate routine annual testing for gonorrhea.

US Public Health Guidelines:

“During the first visit, consider testing all patients for urogenital gonorrhea. For subsequent routine visits, repeated tests periodically (i.e. at least annually) for all patients who are sexually active. More frequent periodic screening (e.g. at 3-month to 6-month intervals) may be indicated for asymptomatic persons at higher risk. Presence of any of the following factors may support more frequent than annual periodic screening: 1) multiple or anonymous sex partners; 2) past history of any STD; 3) identification of other behaviors associated with transmission of HIV and other STDs; 4) sex or needle-sharing partner(s) with any of the above-mentioned risks; 5) developmental changes in life that may lead to behavioral change with increased risky behaviors; or 6) high prevalence of STDs in the area or in the patient population.”⁸

References/Notes:

¹ “Clients” includes all clients aged 13 years or older.

² A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe medications.

³ Onset of sexual activity is not reliably reported or recorded. The lower age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur.

⁴ Cohen MS. Sexually transmitted diseases enhance HIV transmission: no longer a hypothesis. *Lancet* 1998;351(suppl 3):5-7.

⁵ Buchacz K, Patel P, Taylor M, et al. Syphilis increases HIV viral load and decreases CD4 cell counts in HIV-infected patients with new syphilis infections. *AIDS*. 2004 Oct 21;18(15):2075-9.

⁶ DT Fleming and JN Wasserheit, From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection, *Sex Transm Infect* 75 (1999), pp. 3–17.

⁷ CDC. Recommendations and Reports: “Incorporating HIV Prevention into the Medical Care of Persons Living with HIV”. July 18, 2003/52(RR12);1-24.

⁸ Ibid

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Performance Measure: Hepatitis B Screening		OPR-Related Measure: Yes www.hrsa.gov/performance/measure/performancereview/measures.htm
Percentage of clients ¹ with HIV infection who have been screened for Hepatitis B virus infection status		
Numerator:	Number of HIV-infected clients who have documented Hepatitis B infection status ² in the health record	
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges ³ at least once in the measurement year	
Patient Exclusions:	1. Patients with documentation of complete Hepatitis B vaccination	
Data Elements:	1. Is the client HIV-infected? (Y/N) a. If yes, is there documentation of Hepatitis B infection status in the health record? (Y/N)	
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • Medical record data abstraction by grantee of a sample of records • Billing records 	
National Goals, Targets, or Benchmarks for Comparison:	None available at this time.	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> • Hepatitis-related mortality rates in the clinic population 	
Basis for Selection and Placement in Group 3:		
<p>Hepatitis B virus (HBV) is the leading cause of chronic liver disease worldwide. In developed countries, HBV is transmitted primarily through sexual contact and injection drug use. Even though risk factors are similar, HBV is transmitted more efficiently than HIV-1. Up to 90% of HIV-1–infected persons have at least one serum marker of previous exposure to HBV, and approximately 10% have chronic Hepatitis B, as evidenced by the detection of hepatitis B surface antigen (HBsAg) in the serum persisting for a minimum of 6 months.⁴</p> <p>It is not clear that treatment of hepatitis B virus (HBV) improves the course of HIV, nor is there evidence that treatment of HIV alters the course of HBV. However, several liver-associated complications that are ascribed to flares in HBV activity or toxicity of antiretroviral agents can affect the treatment of HIV in patients with HBV coinfection.⁵ Therefore, providers should know the HBV status of all patients with HIV. This also will guide the choice of medications for HIV treatment in the context of any possible HBV treatment. For patients who are HBV negative, prophylaxis is recommended.⁶</p>		

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The measure is placed in Group 3 because it focuses on similar aspects of care (HBV and HCV) previously captured in measures included in Group 2.

US Public Health Guidelines:

“All HIV-infected persons should be tested for HBV infection. Initial testing should be performed because these will identify the majority of patients with chronic hepatitis B or who need vaccination to prevent infection.”⁷

“It is not clear that treatment of hepatitis B virus (HBV) improves the course of HIV, nor is there evidence that treatment of HIV alters the course of HBV. However, several liver-associated complications that are ascribed to flares in HBV activity or toxicity of antiretroviral agents can affect the treatment of HIV in patients with HBV coinfection.”⁸

References/Notes:

¹ “Clients” includes all clients aged 13 years and older.

² Markers of Hepatitis B infection include Hep B Surface Antigen, Hep B e Antigen, Hep B e Antibody or Hep B DNA.

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe medications.

⁴ 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)

⁵ Panel on Antiretroviral Guidelines for Adult 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. (<http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>)

⁶ 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)

⁷ Panel on Antiretroviral Guidelines for Adult 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. (<http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>)

⁸ 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)

HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 3



Performance Measure: Hepatitis/HIV Alcohol Counseling		OPR-Related Measure: No
Percentage of clients ¹ with HIV and Hepatitis B (HBV) or Hepatitis C (HCV) infection who received alcohol counseling ² within the measurement year		
Numerator:	Number of HIV-infected clients who received alcohol counseling	
Denominator:	Number of HIV-infected clients who: <ul style="list-style-type: none"> were co-infected with HBV³ or HCV; and had a medical visit with a provider with prescribing privileges⁴ at least once in the measurement period 	
Patient Exclusions:	None	
Data Elements:	1. Is the client HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, is the client HBV or HCV-positive? (Y/N) <ol style="list-style-type: none"> i. If yes, did the client receive alcohol counseling during the measurement year? (Y/N) 	
Data Sources:	<ul style="list-style-type: none"> Electronic Medical Record/Electronic Health Record CAREWare, Lab Tracker, or other electronic data base Medical record data abstraction by grantee of a sample of records Billing records 	
National Goals, Targets, or Benchmarks for Comparison	None available at this time.	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> Hepatitis-related mortality rates in the clinic population 	
Basis for Selection and Placement in Group 3:		
<p>Discussion of substance use allows the clinician to either provide counseling or make referrals to substance and alcohol treatment centers. A study of HIV positive veterans showed that hazardous drinking and alcohol diagnoses were associated with HIV disease progression and/or hepatic co-morbidity and anemia. It also concluded that alcohol problems are often missed by providers thus increasing the need for routine screening.⁵</p> <p>Long-term studies of patients with chronic HCV infection show that between 2%-20% develop cirrhosis in 20 years. This rate of progression increases with older age, alcoholism and HIV infection.⁶</p> <p>The measure is placed in Group 3 because the definition of “counseling” varies considerably across grantees.</p>		

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The variation in definition impacts the feasibility of data collection.

US Public Health Guidelines:

“All patients with HIV/HCV infection should be advised to avoid or limit alcohol consumption...”⁷

References/Notes:

¹ “Clients” refers to all clients aged 13 years and older.

² For the purposes of this measure, alcohol counseling refers to counseling provided by the primary care team that emphasizes the need to avoid or limit alcohol intake due to the impact on the liver.

³ Markers of Hepatitis B infection include Hep B Surface Antigen, Hep B e Antigen, Hep B e Antibody or Hep B DNA.

⁴ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe medications.

⁵ Joseph Conigliaro, Adam J. Gordon, Kathleen A. McGinnis, Linda Rabeneck, and Amy C.; How Harmful Is Hazardous Alcohol Use and Abuse in HIV Infection: Do Health Care Providers Know Who Is at Risk?; *Journal of Acquired Immune Deficiency Syndromes* 33:521–525.

⁶ 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)

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Performance Measure: Influenza Vaccination		OPR-Related Measure: No
Percentage of clients ¹ with HIV infection who have received influenza vaccination within the measurement period ²		
Numerator:	Number of HIV-infected clients who received influenza vaccination within this time frame	
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges ³ at least once in the measurement period	
Patient Exclusions:	1. Patients allergic to vaccine components	
Data Elements:	1. Is the client HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, is there documentation⁴ in the health record that the client received influenza vaccine in the past 12 months? (Y/N) 	
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • Medical record data abstraction by grantee of a sample of records • Billing records 	
National Goals, Targets, or Benchmarks for Comparison:	None available at this time	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> • Mortality rates of bacterial pneumonia in the clinic population 	
Basis for Selection and Placement in Group 3:		
<p>Influenza viruses cause disease among all age groups. While rates of infection are highest among children, rates of serious illness and death are highest among persons aged ≥ 65 years, children less than 2 years and persons of any age who have medical conditions that place them at increased risk for complications of influenza, including HIV.⁵</p> <p>Influenza vaccination is the most effective method for preventing influenza and its severe complications. Vaccination has been demonstrated to produce substantial antibody titers against influenza among vaccinated HIV-infected persons who have minimal AIDS-related symptoms and high CD4+ T-lymphocyte cell counts.⁶</p> <p>The measure is placed in Group 3 because it overlaps and focuses on similar aspects of care (vaccination) that were previously captured in measures included in Group 2. In addition, the data collection process is more</p>		

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complex because of the timing of the vaccination.

US Public Health Guidelines:

“Annual vaccination against influenza is recommended for...adults and children who have immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus).”⁷

References/Notes:

¹ “Clients” includes all clients aged 13 years and older.

² Due to the unique nature of this measure, the measurement period runs from April 1-March 31.

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe medications.

⁴ Evidence of vaccination could include personal, school, physician, or immunization records or registries.

⁵ Centers for Disease Control and Prevention. Prevention and Control of Influenza: Recommendations from the Advisory committee on Immunization Practices (ACIP). MMWR 2007; 56(RR#6)[1-60]. Available at: <http://www.cdc.gov/mmwr/PDF/rr/rr5606.pdf>.

⁶ Ibid.

⁷ Ibid.

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Performance Measure: MAC Prophylaxis		OPR-Related Measure: No																												
Percentage of clients ¹ with HIV infection with CD4 count < 50 cells/mm ³ who were prescribed <i>Mycobacterium avium</i> Complex (MAC) prophylaxis ² within the measurement year																														
Numerator:	Number of HIV-infected clients with CD4 count < 50 cells/mm ³ who were prescribed MAC prophylaxis																													
Denominator:	Number of HIV-infected clients who had a: <ul style="list-style-type: none"> • CD4 count < 50 cells/mm³; and • medical visit with a provider with prescribing privileges³ at least once in the measurement year 																													
Patient Exclusions:	1. Patients who have disseminated MAC																													
Data Elements:	1. Is the client HIV-infected? (Y/N) <ol style="list-style-type: none"> If yes, was the CD4 count < 50 cells/mm³? (Y/N) <ol style="list-style-type: none"> If yes, was MAC prophylaxis subsequently prescribed? 																													
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records • Billing records 																													
National Goals, Targets, or Benchmarks for Comparison:	National HIVQUAL Data: ⁴ <table border="1"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> <th>2007</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Top 25%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Mean*</td> <td>86.5%</td> <td>84.7%</td> <td>85.7%</td> <td>83.1%</td> <td>84.6%</td> </tr> </tbody> </table> *from HAB data base							2003	2004	2005	2006	2007	Top 10%	100%	100%	100%	100%	100%	Top 25%	100%	100%	100%	100%	100%	Mean*	86.5%	84.7%	85.7%	83.1%	84.6%
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Mean*	86.5%	84.7%	85.7%	83.1%	84.6%																									
Outcome Measures for Consideration:	<ul style="list-style-type: none"> • Incidence of MAC disease in the clinic population • MAC-related mortality rates in the population assessed 																													
Basis for Selection and Placement in Group 3:																														
MAC disease is an opportunistic infection that can cause severe illness in people with advanced AIDS but rarely affects others. The risk of disseminated MAC (DMAC) is directly related to the severity of immunosuppression. DMAC typically occurs in persons with CD4 counts < 50 cells/mm ³ and its frequency increases as the CD4 count declines. In the absence of antibiotic prophylaxis, DMAC occurs in up to 40% of AIDS patients with CD4 counts of < 50 cells/mm. ⁵																														
The measure was placed in Group 3 because it focuses on similar aspects of care (prophylaxis) previously																														

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captured in measures included in Groups 1 & 2.

US Public Health Guidelines:

“Adults and adolescents who have HIV infection should receive chemoprophylaxis against disseminated MAC disease if they have CD4 count < 50 cells/mm.³”⁶

References/Notes:

¹ “Clients” includes all clients aged 13 years and older.

² Current regimens for preventing MAC can be found at: 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)

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe medications.

⁴ MAC Prophylaxis

(<http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>)

⁵ National AIDS Education & Training Centers (2006). Clinical Manual for Management of the HIV-Infected Adult.

⁶ 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)

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Performance Measure: Mental Health Screening	OPR-Related Measure: Yes www.hrsa.gov/performance/measure/mental_health_screening.htm																								
Percentage of new clients ¹ with HIV infection who have had a mental health screening																									
Numerator:	Number of HIV-infected clients who received a mental health screening																								
Denominator:	Number of HIV-infected clients who: <ul style="list-style-type: none"> were new during the measurement year, and had a medical visit with a provider with prescribing privileges² at least once in the measurement year 																								
Patient Exclusions:	None																								
Data Elements:	<ol style="list-style-type: none"> 1. Is the client HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, was the client new to the program during the measurement year? (Y/N) <ol style="list-style-type: none"> i. If yes, did the client receive mental health screening during the measurement year? (Y/N) 																								
Data Sources:	<ul style="list-style-type: none"> Electronic Medical Record/Electronic Health Record CAREWare, Lab Tracker, or other electronic data base HIVQUAL reports on this measure for grantee under review Medical record data abstraction by grantee of a sample of records Billing records 																								
National Goals, Targets, or Benchmarks for Comparison	<p>National HIVQUAL Data:³</p> <table border="1"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> <th>2007</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>100%</td> <td>100%</td> <td>80.6%</td> <td>86.7%</td> <td>100%</td> </tr> <tr> <td>Top 25%</td> <td>93.0%</td> <td>89.5%</td> <td>35.1%</td> <td>52.4%</td> <td>84.0%</td> </tr> <tr> <td>Mean*</td> <td>68.2%</td> <td>58.5%</td> <td>21.9%</td> <td>28.1%</td> <td>42.0%</td> </tr> </tbody> </table> <p>*from HAB data base</p>		2003	2004	2005	2006	2007	Top 10%	100%	100%	80.6%	86.7%	100%	Top 25%	93.0%	89.5%	35.1%	52.4%	84.0%	Mean*	68.2%	58.5%	21.9%	28.1%	42.0%
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Mean*	68.2%	58.5%	21.9%	28.1%	42.0%																				
Outcome Measures for Consideration:	<ul style="list-style-type: none"> Rate of mental health referrals Mental health-related hospitalizations Rate of suicide in the clinic population Rate of mental health disorders being treated in the clinic population 																								
Basis for Selection and Placement in Group 3:																									
Patients living with HIV infection must often cope with multiple social, psychiatric, and medical issues. The ability to cope with these issues can dramatically impact management of the disease. The initial evaluation should include an assessment of substance abuse, economic factors, social																									

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support, mental illness and co-morbidities.⁴

The measure was placed in Group 3 because feasibility of data collection can vary considerably across grantees.

US Public Health Guidelines:

“Patients living with HIV infection must often cope with multiple social, psychiatric, and medical issues. Thus, the (initial) evaluation should also include assessment of substance abuse, economic factors, social support, mental illness, co-morbidities, and other factors that are known to impair the ability to adhere to treatment and to alter outcomes. Once evaluated, these factors should be managed accordingly.”⁵

References/Notes:

¹ “Clients” includes all clients aged 13 years and older.

² A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe medications.

³ The components of the mental health indicator were broken down and implemented for the 2005-2007 data. The Mental Health/Substance Use Subcommittee of the National HIVQUAL Clinical Advisory Committee include the following components for an annual Mental Health Screening for people with HIV: Cognitive function assessment, including mental status; Depression screening; Anxiety screening; Sleeping habits assessment; Appetite assessment; Domestic violence screening; Post Traumatic Stress Disorder screening; Psychiatric history (optional); Psychosocial assessment (optional).

(<http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>)

⁴ Panel on Antiretroviral Guidelines for Adult 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.

(<http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>)

⁵ Ibid

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Performance Measure: Pneumococcal Vaccination		OPR-Related Measure: No				
Percentage of clients ¹ with HIV infection who ever received pneumococcal vaccine						
Numerator:	Number of HIV-infected clients who ever received pneumococcal vaccine					
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges ² at least once in the measurement year					
Patient Exclusions:	1. Patients with CD4 counts < 200 cells/mm ³ within the measurement year					
Data Elements:	1. Is the client HIV-infected? (Y/N) a. If yes, is there documentation ³ in the health record that the client ever received the pneumococcal vaccine? (Y/N)					
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records • Billing records 					
National Goals, Targets, or Benchmarks for Comparison	National HIVQUAL Data: ⁴					
		2003	2004	2005	2006	2007
	Top 10%	100%	95.8%	97.5%	100%	100%
	Top 25%	92.6%	90.8%	93.0%	93.8%	95.1%
	Mean*	79.9%	73.0%	77.1%	79.8%	80.9%
	*from HAB database					
Outcome Measures for Consideration:	<ul style="list-style-type: none"> • Incidence of pneumococcal infection in the clinic population 					
Basis for Selection and Placement in Group 3:						
<p>Bacterial pneumonia is a common cause of HIV-associated morbidity and appears with greater incidence in HIV-infected persons than in the non-infected population. Several risk factors are associated with an increased risk of bacterial pneumonia including CD4 count, injection drug use and smoking.⁵</p> <p>The measure was placed in Group 3 because it overlaps and focuses on similar aspects of care (vaccination) that were previously captured in measures included in Group 2.</p>						
US Public Health Guidelines:						

HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 3



“HIV-infected adults and adolescents who have a CD4+ count of ≥ 200 cells/uL should be administered a single dose of 23-valent polysaccharide pneumococcal vaccine (PPV) unless they have received this vaccine during the previous five years (AII)”. Revaccination can be considered for patients who were initially immunized when their CD4 T lymphocyte counts were < 200 cells/uL in response to HAART (CIII).⁶

References/Notes:

¹ “Clients” includes all clients aged 13 years and older.

² A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe medications.

³ Evidence of vaccination could include physician or immunization records or registries.

⁴ Pneumococcal vaccine

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

⁵ 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)

⁶ Ibid

HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 3



Performance Measure: Substance Use Screening	OPR-Related Measure: Yes www.hrsa.gov/performance/measure/performancereview/measures.htm																								
Percentage of new clients ¹ with HIV infection who have been screened ² for substance use (alcohol & drugs) in the measurement year																									
Numerator:	Number of new HIV-infected clients who were screened for substance use within the measurement year																								
Denominator:	Number of HIV-infected clients who: <ul style="list-style-type: none"> • were new during the measurement year, and • had a medical visit with a medical provider with prescribing privileges³ at least once in the measurement year 																								
Patient Exclusions:	None																								
Data Elements:	<ol style="list-style-type: none"> 1. Is the client HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, was the client new to the program during the reporting period? (Y/N) <ol style="list-style-type: none"> i. If yes, was the client screened for substance use during the measurement year? (Y/N) 																								
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records • Billing records 																								
National Goals, Targets, or Benchmarks for Comparison	<p>IHI Goal: 90%⁴ National HIVQUAL Performance Data:⁵</p> <table border="1"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> <th>2007</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Top 25%</td> <td>92.3%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Mean*</td> <td>73.4%</td> <td>76.5%</td> <td>78.9%</td> <td>81.4%</td> <td>80.6%</td> </tr> </tbody> </table> <p>*from HAB data base</p>		2003	2004	2005	2006	2007	Top 10%	100%	100%	100%	100%	100%	Top 25%	92.3%	100%	100%	100%	100%	Mean*	73.4%	76.5%	78.9%	81.4%	80.6%
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Outcome Measures for Consideration:	<ul style="list-style-type: none"> • Substance use-related mortality rates • Rate of substance use-related hospitalizations • Rate of substance use referrals 																								
Basis for Selection and Placement in Group 3:																									
Patients living with HIV infection must often cope with multiple social, psychiatric, and medical issues.																									

HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 3



The measure was placed in Group 3 because the feasibility of data collection can vary considerably across grantees.

US Public Health Guidelines:

“Patients living with HIV infection must often cope with multiple social, psychiatric, and medical issues. Thus, the (initial) evaluation should also include assessment of substance abuse, economic factors, social support, mental illness, co-morbidities, and other factors that are known to impair the ability to adhere to treatment and to alter outcomes. Once evaluated, these factors should be managed accordingly.”⁶

References/Notes:

¹ “Clients” includes all clients aged 13 years and older.

² The purpose of screening is to identify past or current substance use that negatively impacts linkage to care and health care in general. A substance use screen includes documentation of past and current substance use and treatment in the HIV primary care record. Screening can be provided by any member of the multidisciplinary primary care team.

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe medications.

⁴ IHI Measure reads, “Percent of Patients/Clients Assessed for Substance Use and/or Tobacco Use in the Past 12 Months”

(<http://www.ihl.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientsClientsAssessedforSubstanceUseandorTobaccoUseinthePast12Months.htm>)

⁵ Substance Use Screening

(<http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>)

⁶ Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents (p. 13) (<http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>)

HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 3



Performance Measure: Tobacco Cessation Counseling		OPR-Related Measure: No																									
Percentage of clients ¹ with HIV infection who received tobacco cessation counseling within the measurement year																											
Numerator:	Number of HIV-infected clients who received tobacco cessation counseling																										
Denominator:	Number of HIV-infected clients who: <ul style="list-style-type: none"> used tobacco products within the measurement year; and had a medical visit with a provider with prescribing privileges² at least once in the measurement year 																										
Patient Exclusions:	1. Patients who deny tobacco use throughout the measurement year																										
Data Elements:	1. Is the client HIV-infected? (Y/N) <ul style="list-style-type: none"> a. If yes, did the client use tobacco during the reporting period? (Y/N) <ul style="list-style-type: none"> i. If yes, did the client receive tobacco cessation counseling during the measurement year? (Y/N) 																										
Data Sources:	<ul style="list-style-type: none"> Electronic Medical Record/Electronic Health Record CAREWare, Lab Tracker, or other electronic data base HIVQUAL reports on this measure for grantee under review Medical record data abstraction by grantee of a sample of records Billing records 																										
National Goals, Targets, or Benchmarks for Comparison	National HIVQUAL Data: ³ <table border="1" style="margin-left: 20px;"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> <th>2007</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Top 25%</td> <td>93.3%</td> <td>97.8%</td> <td>98.4%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Mean*</td> <td>69.3%</td> <td>75.0%</td> <td>76.8%</td> <td>81.8%</td> <td>83.8%</td> </tr> </tbody> </table> <p style="margin-left: 20px;">* HAB database</p>				2003	2004	2005	2006	2007	Top 10%	100%	100%	100%	100%	100%	Top 25%	93.3%	97.8%	98.4%	100%	100%	Mean*	69.3%	75.0%	76.8%	81.8%	83.8%
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Outcome Measures for Consideration:	<ul style="list-style-type: none"> Rate of head & neck and lung cancer Rate of tobacco use in the clinic population 																										
Basis for Selection and Placement in Group 3:																											
<p>A recent study has shown that lung cancer rates are 2.7 times greater for people living with HIV.⁴ As tobacco use among HIV-infected patients poses significant health risks, tobacco-dependent patients should be provided assistance to enroll in smoking cessation programs. Various studies have shown that brief interventions by the clinician to encourage tobacco cessation and offer substitution programs can decrease smoking rates⁵ and tobacco use.⁶ Cessation reduces the risk of incidence or the progression of tobacco-related diseases and increases life expectancy.^{7,8,9} HIV care providers should provide cessation assistance in the form of counseling, pharmacotherapy or referral to cessation programs.</p>																											

HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 3



The measure was placed in Group 3 because the feasibility of data collection can vary considerably across grantees.

US Public Health Guidelines:

“The U.S. Preventive Services Task Force strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products.”¹⁰

References/Notes:

¹ “Clients” includes all clients aged 13 years and older.

² A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe medications.

³ Tobacco Use

(<http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>)

⁴ Philips, Abs 8, CROI, Boston, 2008.

⁵ Page AR, Walters DJ, Schlegel RP, Best JA. Smoking cessation in family practice: The effects of advice and nicotine chewing gum prescription. *Addict Behav* 1986;11(4):443-6.

⁶ Demers RY, Neale AV, Adams R, Trembath C, Herman SC. The impact of physicians' brief smoking cessation counseling: A MIRNET study. *J Fam Pract* 1990;31(6):625-9.

⁷ Rigotti NA. Treatment of tobacco use and dependence. *N Engl J Med* 2002;346:506-512.

⁸ Lancaster T, Stead L, Silagy C, Sowden A. Effectiveness of interventions to help people stop smoking: findings from the Cochrane Library. *BMJ* 2000;321:355-8.

⁹ Methods, Successes, and Failures of Smoking Cessation Programs E B Fisher Jr., E Lichtenstein, D Haire-Joshu, G D Morgan, H R Rehberg *Annual Review of Medicine*, February 1993, Vol. 44, Pages 481-513.

¹⁰ Agency for Healthcare Research and Quality. *The Guide to Clinical Preventive Services: Recommendations of the U.S. Preventive Services Task Force*, June 2006, p. 120.

HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 3



Performance Measure: Toxoplasma Screening		OPR-Related Measure: No
Percentage of clients ¹ with HIV infection for whom Toxoplasma screening ² was performed at least once since the diagnosis of HIV infection ³		
Numerator:	Number of HIV-infected clients who have documented Toxoplasma status in health record	
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges ⁴ at least once in the measurement year	
Patient Exclusions:	1. Patients with known toxoplasmic disease, e.g. <i>Toxoplasma gondii</i> encephalitis	
Data Elements:	1. Is the client HIV-infected? (Y/N) a. If yes, is there documentation of the client’s Toxoplasma status in the health record? (Y/N)	
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker or other electronic data base • Medical record data abstraction by grantee of a sample of records • Billing records 	
National Goals, Targets, or Benchmarks for Comparison:	None available at this time	
Outcomes Measures for Consideration:	<ul style="list-style-type: none"> • Toxoplasmosis-related mortality rates in the clinic population • Incidence of Toxoplasmosis in the clinic population 	
Basis for Selection and Placement in Group 3:		
<p>Toxoplasmic disease appears to occur almost exclusively because of reactivation of latent tissue cysts. Clinical disease is rare among patients with CD4 counts >200 cells/uL. The greatest risk is among patients with a CD4 cell count < 50/uL. HIV-infected patients with <i>Toxoplasma gondii</i> encephalitis (TE) are almost uniformly seropositive for anti-toxoplasma IgG antibodies.⁵</p> <p>The measure is placed in Group 3 because it overlaps and focuses on similar aspects of care (prophylaxis) previously captured in measures included in Group 1. Certain geographic regions have lower rates of toxoplasmic disease.</p>		
US Public Health Guidelines:		
<p>“HIV-infected persons should be tested for immunoglobulin G (IgG) antibody to Toxoplasma soon after the diagnosis of HIV infection to deter latent infection with <i>T. gondii</i> (strength of recommendation: BIII).”⁶</p> <p>“<i>Toxoplasma</i>-seronegative persons who are not taking a PCP prophylactic regimen known to be active</p>		

HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 3



against TE should be retested for IgG antibody to *Toxoplasma* when their CD4+ counts decline to $<100/uL$ to determine whether they have seroconverted and are therefore at risk for TE (strength of recommendation: CIII).⁷

References/Notes:

¹ “Clients” refers to all clients aged 13 years and older.

²Toxoplasma screening refers to testing for the presence of anti-toxoplasma immunoglobulin G (IgG) antibodies to detect latent infection with *Toxoplasma gondii*.

³Unless there is concern about ongoing exposure, annual re-screening is not generally recommended.

⁴ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe medications.

⁵Centers 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)

⁶Ibid

⁷Ibid