

HAB HIV Performance Measures: Systems-Level

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| Performance Measure: System Level: Waiting time for initial access to outpatient/ambulatory medical care | |
| Percent of Ryan White Program-funded outpatient/ambulatory care organizations in the system/network with a waiting time of 15 or fewer business days for a Ryan White Program-eligible patient to receive an appointment to enroll in outpatient/ambulatory medical care ¹ | |
| Numerator: | Number of Ryan White Program-funded outpatient/ambulatory medical care organizations in the system/network with a waiting time of 15 or fewer business days for a Ryan White Program-eligible patient to receive an appointment to enroll in outpatient/ambulatory medical care ¹ . |
| Denominator: | Number of Ryan White Program-funded outpatient/ambulatory medical care organizations in the system/network at a specific point in time in the measurement year. |
| Exclusions: | None |
| Data Element: | <p><i>For each agency:</i></p> <ol style="list-style-type: none"> 1. Is the organization funded by the Ryan-White Program to provide outpatient/ambulatory medical care? (Y/N) <ol style="list-style-type: none"> a. In how many business days is the third next available appointment for a Ryan White Program-eligible patient to enroll in outpatient/ambulatory medical care at this organization? <ol style="list-style-type: none"> i. Is the third next available appointment \leq 15 business days? (Y/N) <p><i>For the system:</i></p> <ol style="list-style-type: none"> 1. How many outpatient/ambulatory medical care organizations are funded by the Ryan White Program to provide outpatient/ambulatory medical care? <ol style="list-style-type: none"> a. Of those organizations, how many have \leq 15 business days for the third next available appointment to enroll in outpatient/ambulatory medical care? |
| Data Sources: | <ul style="list-style-type: none"> • Data reported to the system/network grantee at a common point in time on a quarterly basis by each of the organizations in the system/network that provides outpatient/ambulatory medical care using a standardized methodology. (See example below.) |
| 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 outpatient/ambulatory medical care in the measurement year. • Percent of patients diagnosed with <i>Pneumocystis jiroveci</i> (PCP) in the measurement year. |

HAB HIV Performance Measures: Systems-Level



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| <p>Basis for Selection:</p> <p>This measure addresses the importance of access to health care for Ryan White Program eligible patients. 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 A study of the characteristics of scheduled new HIV+ patients who failed to attend their initial visit found that in addition to patient characteristics (younger age, black race, and public insurance), “longer waiting time from the call to schedule a new patient visit to the appointment date was associated with failure to establish care.”³</p> |
| <p>US Public Health Service Guidelines:</p> <p>None</p> |
| <p>References/Notes:</p> <p>¹ The type of visit for patient enrollment in outpatient/ambulatory medical care can be determined by each outpatient/ambulatory medical care provider in the system/network, but should be consistently defined at each data collection point. The type of appointment scheduled to enroll in outpatient/ambulatory medical care may vary among agencies within the system/network. For example, at one agency, to enroll in care, a new patient may first have an appointment to have routine laboratory tests and an initial health history taken by a nurse to then be followed by a subsequent appointment with a provider with prescribing privileges at the agency (i.e., MD, PA, NP), while at another agency, a new patient may first have an appointment with physician. Other examples of types of appointment to enroll in outpatient/ambulatory medical care may include an initial appointment with a case manager, social worker, patient navigator, peer advocate, clergy, or other designated staff.</p> <p>² National Quality Measures Clearinghouse, “Access: time to third next available appointment for an office 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).</p> <p>³ Mugavero MJ, Lin HY, Alison JJ, et al. Failure to Establish HIV Care: Characterizing the “No Show” Phenomenon. <i>Clinical Infectious Diseases</i>. 2007;45:127-130.</p> |
| <p>Example:</p> <p>System A, which has six (6) outpatient medical care programs, decided to implement this measure on a quarterly basis. A point in time survey was scheduled to be conducted by telephone on the last Tuesday of the quarter. (Other methods of data collection, such as an on-line survey, e-mail, or fax may be used to collect data at the point in time by the system.) On the designated morning the System A administrative staff calls each outpatient program and asks the following question: “What are your three next available appointments for an individual who is seeking to enroll in outpatient/ambulatory medical care for his/her HIV disease at your clinic?”</p> <p>After data is collected from each of the agencies, the waiting time (number of business days from the date of data collection to the appointment date) are calculated for the third next available appointment. Those which are fifteen business days or fewer are identified and are counted as the numerator; while the denominator is the total number of ambulatory outpatient medical care providers in the system.</p> |

HAB HIV Performance Measures: Systems-Level

Results of System A Point in Time Survey

Date of data collection: September 14, 2010 (N=6)

| Agency 1 | | | Agency 2 | | |
|-----------------|------------|-----------------|-----------------|------------|-----------------|
| | Days | Within 15 days? | | Days | Within 15 days? |
| 1st appointment | 9/14/2010 | 0 | 1st appointment | 9/14/2010 | 0 |
| 2nd appointment | 9/23/2010 | 7 | 2nd appointment | 9/14/2010* | 0 |
| 3rd appointment | 10/15/2010 | 23 | 3rd appointment | 9/14/2010 | 0 |
| | | No | | | Yes |

| Agency 3 | | | Agency 4 | | |
|-----------------|------------|-----------------|-----------------|-----------|-----------------|
| | Days | Within 15 days? | | Days | Within 15 days? |
| 1st appointment | 11/24/2010 | 50 | 1st appointment | 9/21/2010 | 5 |
| 2nd appointment | 12/15/2010 | 64 | 2nd appointment | 9/21/2010 | 5 |
| 3rd appointment | 1/19/2011 | 88 | 3rd appointment | 9/22/2010 | 6 |
| | | No | | | Yes |

| Agency 5 | | | Agency 6 | | |
|-----------------|------|-----------------|-----------------|-----------|-----------------|
| | Days | Within 15 days? | | Days | Within 15 days? |
| 1st appointment | None | | 1st appointment | 9/14/2010 | 0 |
| 2nd appointment | None | | 2nd appointment | 9/17/2010 | 3 |
| 3rd appointment | None | No | 3rd appointment | 9/20/2010 | 4 |
| | | | | | Yes |

**Note: Different appointment times on the same day counts as separate appointment times.*

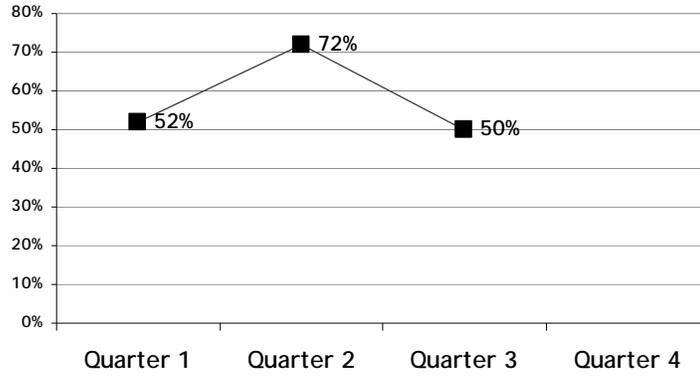
Using the data collected, the performance measure is calculated by identifying the number of agencies that indicate that their third next available appointment is within 15 or fewer business days. In the example above, three of the agencies meet this criteria (Agencies 2, 4 and 6) and three (Agencies 1, 3 and 5) do not. Even though Agency 5 is closed to new patients, they are still included. The numerator is 3 and the denominator is 6. The percent of Ryan White Program-funded outpatient/ambulatory medical care organizations in the system/network with a waiting time of 15 or fewer business days for a Ryan White Program-eligible patient to receive an appointment to enroll in outpatient/ambulatory medical care at this point in time is 50%. (Calculated by dividing the numerator by the denominator: $(3 \div 6) \times 100 = 50\%$)

In addition to determining the rate of achievement of the performance measure, the average number of days until the third next available appointment across the system/network can also be calculated: Add the number of days for the third next available appointments (in this example the sum is 121 days) and then divide by the number of agencies in the system who report an available appointment (in this example the number is 5). The average number of days for the third next available appointment in the system/network reported on the date of data collection is 24.2 days. (Note: In this example Agency 5 reports that it is not accepting new patients—no appointments are available. This agency should still be included in the denominator for the calculation of the performance measure rate [Example 1] but it should not be included in the denominator for the calculation of the average number of days [Example 2].)

Figure 1 depicts percentage of agencies meeting the performance measure over three quarters.

HAB HIV Performance Measures: Systems-Level

Example: Graph of wait time performance measure for System: Performance measure rate for Quarters 1-3



HAB HIV Performance Measures: Systems-Level

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| Performance Measure: System Level: HIV test results for PLWHA | |
| Percentage of individuals who test positive ¹ for HIV who are given their HIV-antibody test results in the measurement year | |
| Numerator: | Number of individuals who are tested in the system/network who test positive ¹ for HIV and who are given their HIV antibody test results in the measurement year. |
| Denominator: | Number of individuals who are tested in the system/network and who test positive ¹ 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 a previous positive confirmatory test (i.e., confirmatory test at first medical care visit). 4. Patients who are less than thirteen years of age. |
| Data Element: | <p><i>For each agency:</i></p> <ol style="list-style-type: none"> 1. Was the patient tested for HIV infection during the measurement year? (Y/N) <ol style="list-style-type: none"> a. If yes, did the patient have a positive confirmatory test¹? (Y/N) <ol style="list-style-type: none"> i. If yes, was the patient given his/her confirmatory test result in the measurement year? (Y/N) <p><i>For the system:</i></p> <ol style="list-style-type: none"> 1. How many patients were tested for HIV infection within the system/network in the measurement year? <ol style="list-style-type: none"> a. How many patients had positive confirmatory tests? <ol style="list-style-type: none"> i. Of those patients, how many received the confirmatory test results? |
| Data Sources: | <ul style="list-style-type: none"> • Data reports required by HRSA/HAB, such as the Ryan White Data Report (RDR) and Ryan White HIV/AIDS Program Services Report (RSR), may provide useful data regarding the number of patients identified receiving HIV antibody testing at the system level. • Electronic databases, such as CAREWare, Lab Tracker, PEMS, Electronic Medical Record/Electronic Health Record • Surveillance data systems |
| 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 entering outpatient/ambulatory medical care with an AIDS diagnosis in the measurement year. • Percent of HIV+ patients linked to outpatient/ambulatory medical care in the measurement year. |
| Basis for Selection: | |

HAB HIV Performance Measures: Systems-Level

“The U.S. Preventive Services Task Force 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.”²

The Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87) further emphasized the importance of identifying individuals with HIV/AIDS who do not know their HIV status, making them aware of their status, and referring them into treatment and care.³

US Public Health Service Guidelines:

“Diagnostic HIV testing and opt-out health screening [should] 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 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”²

References/Notes:

¹“Test positive” includes only a confirmatory HIV test, regardless of the test used.

²Centers 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

³“Ryan White HIV/AIDS Treatment Extension Act of 2009”. (P.L. 111-87), 42 USC 201.

HAB HIV Performance Measures: Systems-Level

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| Performance Measure: System Level: Disease status at time of entry into care | |
| Percentage of individuals with an AIDS diagnosis at time of initial outpatient/ambulatory medical care visit ¹ in the measurement year | |
| Numerator: | Number of patients in the system/network meeting the CDC-AIDS diagnostic criteria ² within 30 days of the initial outpatient/ambulatory medical care visit ¹ in the measurement year |
| Denominator: | Number of patients in the system/network initiating outpatient/ambulatory medical care ³ in the measurement year |
| Patient Exclusions: | <ol style="list-style-type: none"> 1. Patients who previously received HIV-related outpatient/ambulatory medical care at another organization, regardless of geographic area and/or payor 2. Patients who are less than thirteen years of age |
| Data Element: | <p><i>For each agency:</i></p> <ol style="list-style-type: none"> 1. Did the patient have an initial outpatient/ambulatory medical care visit¹ during the measurement year? (Y/N). <ol style="list-style-type: none"> a. If yes, did the patient meet the CDC AIDS-diagnostic criteria² within 30 days of the initial outpatient/ambulatory medical care visit? (Y/N) <ol style="list-style-type: none"> i. If yes, list the date of initial visit and date of AIDS diagnosis, if applicable. <p><i>For the system:</i></p> <ol style="list-style-type: none"> 1. For all agencies, how many patients had an initial outpatient/ambulatory medical care visit¹ during the measurement year? <ol style="list-style-type: none"> a. Of those patients, how many met the CDC AIDS diagnostic criteria² within 30 days of the initial medical visit? |
| Data Sources: | <ul style="list-style-type: none"> • Data reports required by HRSA/HAB, such as the Ryan White Data Report (RDR) and Ryan White HIV/AIDS Program Services Report (RSR), may provide useful data regarding the number of patients identified with AIDS within 30 days of their initial visit. • Electronic databases, such as CAREWare, Lab Tracker, PEMS, Electronic Medical Record/Electronic Health Record • State surveillance records • Provider patient rosters |
| National Goals, Targets, or Benchmarks for Comparison: | Part C data (historical) indicates 40% of new patients had an AIDS diagnosis [HAB data] |
| Outcome Measures for Consideration: | <ul style="list-style-type: none"> • Percent of patients with opportunistic infections in the measurement year • Percent of patients with HIV-related hospitalizations in the measurement year • Rate of HIV-related mortality in the measurement year |

HAB HIV Performance Measures: Systems-Level

Basis for Selection:

“Advances in HIV care have resulted in dramatic reductions in HIV-associated morbidity and mortality. To benefit optimally from antiretroviral and prophylactic medications, HIV-infected persons must know their HIV status, access care early in the course of disease, and remain engaged in care.”⁴

“To maximally benefit from HAART, persons with HIV infection must receive a diagnosis before an advanced stage of immunosuppression and then enter quality HIV care”⁵ The proportion of persons presenting with an AIDS-defining condition at time of diagnosis of HIV infection “has been 25%-to 50% in selected rural and urban jurisdictions from which data have been reported.”⁶ A multi-year study in an urban clinic found that despite efforts to increase HIV testing and early entry into care “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”⁷

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. The Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87) further emphasized the importance of identifying individuals with HIV/AIDS who do not know their HIV status, making them aware of their status, and referring them into treatment and care.⁸

US Public Health Service Guidelines:

This measure addresses the intent of HHS Treatment Guidelines for the use of antiretroviral agents and the prevention and treatment of opportunistic infections in HIV infected individuals.⁹⁻¹⁰

References/Notes:

¹ The type of visit for patient enrollment in outpatient/ambulatory medical care can be determined by each outpatient/ambulatory medical care providers in the system/network, but should be consistently defined at each data collection point. The type of appointment scheduled to enroll in outpatient/ambulatory medical care may vary among agencies within the system/network. For example, at one agency, to enroll in care, a new patient may first have an appointment to have routine laboratory tests and an initial health history taken by a nurse to then be followed by a subsequent appointment with a provider with prescribing privileges at the agency (i.e., MD, PA, NP), while at another agency, a new patient may first have an appointment with physician. Other examples of types of appointment to enroll in outpatient/ambulatory medical care may include an initial appointment with a case manager, social worker, patient navigator, peer advocate, clergy, or other designated staff.

² AIDS Defining conditions are noted in CDC. 1993 Revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. MMWR 1992;41(no. RR-17). (<http://www.cdc.gov/mmwr/preview/mmwrhtml/00018871.htm>)

³ “Initiating outpatient medical care” refers to patients enrolling in medical care for the first time within the system or network. ⁴ Giordano, et. al. Retention in Care: A Challenge to Survival with HIV Infection. *Clinical Infectious Diseases*. 2007.44:1493-9.

⁵ Brooks JT, Kaplan J, et al. “HIV Associated Opportunistic Infections—Going, Going, But Not Gone: The Continued Need for Prevention and Treatment Guidelines.” *Clinical Infectious Diseases*. 2009;48:609-11.

⁶ Keruly and Moore. Immune Status at Presentation to Care Did Not Improve among Antiretroviral-Naïve Persons from 1990 to 2006. *Clinical Infectious Diseases*. 2007: 45:1369-74.

HAB HIV Performance Measures: Systems-Level

⁷“Ryan White HIV/AIDS Treatment Extension Act of 2009”. (P.L. 111-87), 42 USC 201.

⁸ 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. December 1, 2009; 1-161. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed December 7, 2009.

⁹ Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. MMWR 2009;58 (No. RR-4): 1-216. Available at: <http://www.cdc.gov/mmwr/pdf/rr/rr5804.pdf>. Accessed September 9, 2009.

¹⁰ Perinatal HIV Guidelines Working Group. Public Health Service Task Force Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. April 29, 2009; pp 1-90. Available at <http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf>. Accessed September 9, 2009.

HAB HIV Performance Measures: Systems-Level

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| Performance Measure: System Level: Quality management program | |
| Percentage of Ryan White Program-funded clinical organizations with an HIV-specific quality management program ¹ 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 ¹ in the measurement year |
| Denominator: | Number of Ryan White Program-funded clinical organizations in the system/network in the measurement year |
| Exclusions: | 1. Organizations funded by the Ryan White Program to only provide services other than ambulatory outpatient medical services |
| Data Element: | <p><i>For each agency:</i></p> <ol style="list-style-type: none"> 1. Is the clinical organization Ryan White Program-funded? (Y/N) <ol style="list-style-type: none"> a. If yes, did the clinical organization have an HIV-specific clinical quality management program¹ during the measurement year? (Y/N) <p><i>For the system:</i></p> <ol style="list-style-type: none"> 1. How many clinical organizations are funded by the Ryan White Program? <ol style="list-style-type: none"> a. Of those organizations, how many have an HIV-specific quality management program¹ during the measurement year? |
| Data Sources: | <ul style="list-style-type: none"> • Data reports required by HRSA/HAB, such as the Ryan White Data Report (RDR) and Ryan White HIV/AIDS Program Services Report (RSR), may provide useful data regarding the number clinical organizations and the number of quality management programs. • Ryan White grantee contract language and contract monitoring • Quality management program documentation |
| National Goals, Targets, or Benchmarks for Comparison: | 92.3% 2008 Ryan White Program Data Report Goal: 100% [legislative requirement] |
| 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” and “Ryan White HIV/AIDS Treatment Extension Act of 2009” further delineated these requirements. 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.^{2,3} <p>A quality management program is defined by HRSA/HAB as:</p> | |

HAB HIV Performance Measures: Systems-Level

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 patient 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 [The Joint Commission] 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.⁴

US Public Health Service Guidelines:

None

References/Notes:

¹ An “HIV-specific quality management program” is a quality management program operated by the Ryan White Program that includes a written quality management plan and that identifies quality indicators and/or quality goals which are specific to HIV care, for example, HAB HIV/AIDS Core Clinical Performance Measures (available at: <http://hab.hrsa.gov/special/habmeasures.htm>).

² Public Law 109-415, Ryan White HIV/AIDS Treatment Modernization Act of 2006, 42 USC 201.

³ Public Law 111-187, Ryan White HIV/AIDS Treatment Extension Act of 2009, 42 USC 201.

⁴ HRSA/HAB, “HRSA Quality Management Technical Assistance Manual”, 2003. Available at: <http://hab.hrsa.gov/tools/QM/>.

HAB HIV Performance Measures: Systems-Level

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| Performance Measure: System-Level Performance |
| Rate of achievement (percentage of patients) of the performance measurement of interest* in the system/network in the measurement year |
| Use of Measure: Grantees that provide systems or networks of care, or that fund multiple organizations or providers to deliver services must look at the quality of these services across the system of care. This performance measure serves as a guide on how to use HAB performance measures at the system-level. The system-level rate provides the average likelihood of a patient receiving the quality component within the system (answering the question: “How well is the system doing on this measure?”), while the agency-level rates provides the likelihood of a patient receiving the quality component within each of the system’s agency (answering the question: “How well is each agency doing on this measure?”). These rates (system and agency-level) can be used by the system to help establish quality goals and benchmarks, identify quality improvement efforts and best practices. |
| Example: |

HAB HIV Performance Measures: Systems-Level

Example:

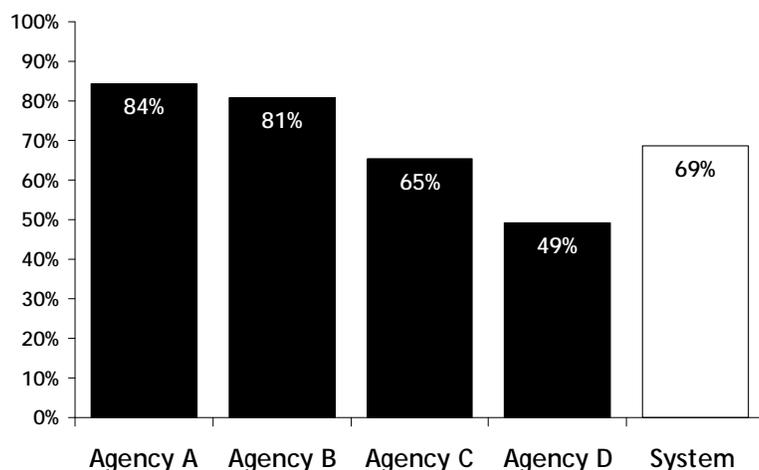
System A, which has four (4) outpatient/ambulatory medical care organizations, selected the Medical Visits¹ performance measure to examine. Each agency collected and reported to the System A administrator the data for all patients which met the HAB performance measure inclusion and exclusion criteria for the defined measurement year. The table below shows the reported data. The performance rate for each of the four agencies is separately calculated (bottom row). The performance rate for the entire system is also calculated by summing the numerators and denominators for the four agencies. (Note: See the FAQs for questions regarding calculation of this measure if a representative sampling methodology is used.)

HAB Performance Measure: Medical Visits:

Percentage of patients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year.

| | Agency A | Agency B | Agency C | Agency D | System-Level Performance |
|------------------|----------|----------|----------|----------|--------------------------|
| Numerator | 64 | 365 | 924 | 55 | 1,408 |
| Denominator | 76 | 452 | 1,412 | 112 | 2,052 |
| Performance Rate | 84% | 81% | 65% | 49% | 69% |

Graph of System and agency-level rate of performance: HAB Performance Measure: Medical Visits:



Basis for Selection:

Quality management requirements were first introduced in 2000 reauthorization of “Ryan White CARE Act.” “Ryan White Treatment and Modernization Act of 2006” (P.L. 109-415) and “Ryan White HIV/AIDS Treatment Extension Act of 2009” further delineated these requirements. All RW Program 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

HAB HIV Performance Measures: Systems-Level

- Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services.^{2,3}

The HAB HIV 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.”⁴

US Public Health Service Guidelines:

See corresponding HAB HIV Performance Measures.*

References/Notes:

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

¹Medical Visit performance measure: Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year. Available at

<http://www.hab.hrsa.gov/special/performance/measureMedVisits.htm>.

² Public Law 109-415, Ryan White HIV/AIDS Treatment Modernization Act of 2006, 42 USC 201.

³Public Law 111-187, Ryan White HIV/AIDS Treatment Extension Act of 2009, 42 USC 201.

⁴ “Quality of Care: HAB Performance Measures Companion Guide ”, accessed at:
<http://hab.hrsa.gov/special/performance/faqData09.htm#data1> on 3 February 2010.