

Appendix B

HIV Performance Measures

The following performance indicators are measured system wide to assess the impact of HIV services on the health status of the people living with HIV/AIDS in the Houston EMA. These indicators are based on current HHS Guidelines for HIV/AIDS health care and community input, and will be revised annually to reflect new directives.

Clinical Case Management

- A minimum of 75% of clients will utilize Part A/B/C/D primary care at least two or more times three months apart after accessing clinical case management
- Increase in the percent of clients who utilize mental health services after accessing clinical case management.
- 75% of clients for whom there is lab data in the CPCDMS will show improved or maintained CD-4 counts over time
- Percent of clients for whom there is lab data in the CPCDMS who are virally suppressed (<200)
- Percent of clients identified with an active substance abuse condition receiving Ryan White funded substance abuse treatment
- Percent of clients identified with an active mental health condition receiving Ryan White funded counseling services
- Percent of homeless or unstably housed clients who attended a routine HIV medical care visit within 3 months of HIV diagnosis

Legal Services

- Change in the number of permanency planning cases completed over time
- 65% of completed SSI disability, insurance, public benefits and income-related cases will result in access to or continued access to benefits

Local Pharmacy Assistance

- 75% of clients for whom there is lab data in the CPCDMS will show improved or maintained CD-4 counts over time
- Percent of clients for whom there is lab data in the CPCDMS who are virally suppressed (<200)

Medical Case Management

- A minimum of 85% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing medical case management
- Increase in the percent of clients who utilize mental health services after accessing

medical case management.

- Increase in the percentage of clients who have 3rd party payer coverage (e.g. Medicare, Medicaid) after accessing medical case management.
- 75% of clients for whom there is lab data in the CPCDMS will show improved or maintained CD-4 counts over time
- Percent of clients who are virally suppressed (<200)
- Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits
- Percentage of patients with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year
- Percentage of HIV-infected medical case management clients who had a medical case management care plan developed and/or updated two or more times in the measurement year.
- Percent of homeless or unstably housed clients who attended a routine HIV medical care visit within 3 months of HIV diagnosis

Medical Nutritional Supplements

- 90% of clients will show improved or maintained CD-4 counts over time
- Percent of clients for whom there is lab data in the CPCDMS who are virally suppressed (<200)

Oral Health

- Percentage of HIV-infected oral health patients who had a dental and medical health history (initial or updated) at least once in the measurement year.
- Percentage of HIV-infected oral health patients who had a dental treatment plan developed and/or updated at least once in the measurement year.
- Percentage of HIV-infected oral health patients who received oral health education at least once in the measurement year.
- Percentage of HIV-infected oral health patients who had a periodontal screen or examination at least once in the measurement year.
- Percentage of HIV-infected oral health patients with a Phase 1 treatment plan that is completed within 12 months.
- 75% of diagnosed HIV/AIDS-related and general oral pathologies will be resolved, improved or maintained at most recent follow-up.

Primary Medical Care

- 100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network with a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an appointment to enroll

in outpatient/ambulatory medical care

- 90% of clients with HIV infection will have two or more medical visits, 90 days apart, in an HIV care setting in the measurement year
- 75% of clients will show improved or maintained CD-4 counts over time
- Percent of clients who have a CD4 < 200 within the first 90 days of initial enrollment in primary medical care
- Percent of clients who are virally suppressed (<200)
- Percentage of patients aged six months and older with a diagnosis of HIV/AIDS, with at least two CD4 cell counts or percentages performed during the measurement year at least 3 months apart
- Percentage of patients with a diagnosis of HIV/AIDS, who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis
- Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy
- Percent of female clients with a diagnosis of HIV who have a pap screening in the measurement year
- Percentage of clients with HIV infection who completed the vaccination series for Hepatitis B
- Percentage of clients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV infection
- Percentage of clients with HIV infection who received HIV risk counseling within the measurement year
- Percent of clients with a diagnosis of HIV who have been screened for substance abuse (alcohol and drugs) in the measurement year
- Percentage of clients with HIV infection who received HIV risk counseling within the measurement year
- Percentage of patients with a diagnosis of HIV who were prescribed HIV antiretroviral therapy and who had a fasting lipid panel during the measurement year
- Percent of clients with HIV infection who received an oral exam by a dentist at least once during the measurement year
- Percent of clients with a diagnosis of HIV at risk for sexually transmitted infections who had a test for gonorrhea and chlamydia within the measurement year.
- Percent of clients with a diagnosis of HIV who had a test for syphilis performed within the measurement year
- Percentage of patients with a diagnosis of HIV/AIDS, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection
- Percentage of clients with HIV infection who have been screened for Hepatitis B virus infection status (ever)
- Percentage of patients seen for a visit between October 1 and March 31 who received

an influenza immunization OR who reported previous receipt of an influenza immunization

- Percentage of patients aged screened for clinical depression using a standardized tool and follow up plan documented.
- Percentage of clients with HIV infection who ever received pneumococcal vaccine
- Percentage of patients who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user
- Percentage of patients with a diagnosis of HIV/AIDS with a viral load test performed at least every six months during the measurement year
- Percentage of patients with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year
- Percentage of patients with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits
- Percentage of patients with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year
- Percentage of patients with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year
- Percentage of patients with a diagnosis of HIV who had an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year

Non-Medical Case Management/Service Linkage

- A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing community-based case management (service linkage)
- Number of days between first ever service linkage visit and first ever primary medical care visit (Mean, Median, &/or Mode)
- Percentage of newly enrolled patients who had a medical visit in each of the 4-month periods of the measurement year

Substance Abuse

- A minimum of 70% of clients will utilize Part A/B/C/D primary medical care after accessing Part A funded substance abuse treatment services
- Change in the rate of program completion over time
- 75% of clients for whom there is lab data in the CPCDMS will increase or maintain CD4 counts over time
- Percent of clients for whom there is lab data in the CPCDMS who are virally suppressed (<200)

Transportation

- A minimum of 50% of clients will utilize Part A/B/C/D primary care services after accessing transportation services.
- 35% of clients will utilize Part A/B LPAP services after accessing Van Transportation services.
- A minimum of 50% of clients will utilize Part A/B/C/D primary care services after accessing transportation services.
- A minimum of 20% of clients will utilize Part A/B LPAP services after accessing Bus Pass services.
- A minimum of 65% of clients will utilize any RW Part A/B/C/D or State Services service after accessing Bus Pass services.

Vision

- 75% of clients with diagnosed HIV/AIDS related and general ocular disorders will resolve, improve, or stay the same over time
- Percentage of HIV-infected vision patients who had a vision and medical health history (initial or updated) at least once in the measurement year.
- Percentage of HIV-infected vision patients who had a comprehensive eye examination at least once in the measurement year.

Appendix C

Performance Improvement Goals for FY 2014

The following performance goals consist of process and outcome indicators and are based on US Department of Health and Human Services guidelines and areas identified for improvement from review of the Houston EMA FY 2011 chart review reports, outcomes and needs assessment data. National goals and Benchmarks being utilized for comparisons include Institute of Health Care Improvement (IHI) goals for HIV/AIDS care and the 2007 HIVQUAL Performance Data Report. Ryan White Part A funded providers are required to implement improvement projects that will facilitate the attainment of these system-wide goals.

Primary Medical Care

- 90% of clients with HIV infection will have two or more medical visits, 90 days apart, in an HIV care setting in the measurement year
- Percent of clients who are virally suppressed (<200)
- Percentage of female clients who have a pap screening in the measurement year
- Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year

Non-Medical Case Management/Service Linkage

- Percentage of newly enrolled patients who had a medical visit in each of the 4-month periods of the measurement year