

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

Performance Measure 2.1: Ophthalmology Screen		OPR-Related Measure: N/A													
Percent of patients ¹ with HIV-infection with CD4 count < 50 cells/mm ³ with documented ophthalmology referral within the measurement year.															
Numerator:	Number of patients who received an ophthalmology referral in the measurement year														
Denominator:	Number of patients with HIV-infection who: <ul style="list-style-type: none"> • had a medical visit with a provider with prescribing privileges² at least twice in the measurement year; and • had a CD4 count < 50 cells/mm³ during the measurement year 														
Patient Exclusions:	1. Patient refusal of ophthalmology referral documented in medical record														
Data Element:	1. Is the patient HIV-positive? (Y/N) <ol style="list-style-type: none"> If yes, did the patient have a CD4 count performed during the reporting period? (Y/N) <ol style="list-style-type: none"> If yes, was the patient's CD4 count < 50 cells/mm³ at any point? (Y/N) <ol style="list-style-type: none"> If yes, did the patient receive an ophthalmology referral? (Y/N) 														
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records. 														
National Goals, Targets, or Benchmarks for Comparison:	Office of AIDS Programs and Policy (OAPP) Threshold For Compliance (TFC) = 90% National HIVQUAL Data: ³ <table border="1" style="margin-left: 20px;"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> </tr> </thead> <tbody> <tr> <td>Top 10%</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> </tr> </tbody> </table> *from HAB data base				2003	2004	2005	Top 10%	100%	100%	100%	Top 25%	100%	100%	100%
	2003	2004	2005												
Top 10%	100%	100%	100%												
Top 25%	100%	100%	100%												
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Incidence of CMV retinitis in clinic population 														
Basis for Selection and Placement in HAB Draft Group 3:															
<p>Immunosuppression caused by HIV-infection increases the incidence of eye infections; however, serious eye problems associated with advanced immunosuppression are less common in patients treated with ART. More severely immunocompromised patients, CD4 count < 100 cells/mm³, may experience CMV retinitis, <i>Toxoplasma</i> retinochoroiditis, cryptococcal chorioretinitis, and other conditions.^{4,5}</p> <p>Drug induced ocular toxicity can be caused by rifabutin, ethambutol, cidofovir, and less often by high-dose didanosine, intravenous ganciclovir, intravenous acyclovir, and atovaquone.</p> <p>While the Public Health Service (PHS) Guidelines do not define the frequency of ophthalmology screens, it is considered a best practice to screen patients every 12 months if CD4 counts are < 50 cells/mm³.</p>															
US Public Health Guidelines:															
Regular fundoscopic examinations performed by an ophthalmologist are recommended by certain specialists for patients with low CD4 counts (< 50 cells/mm ³) ⁵															
References/Notes:															

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

¹“Patients” include all patients aged 13 years or older.

²A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

³<http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.

⁴ National AIDS Education & Training Centers (2006). Clinical Manual for Management of the HIVInfected Adult.

⁵ Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.

<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

DRAFT

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

Performance Measure 2.2: Chlamydia Screen (HAB Group 3)		OPR-Related Measure: N/A
Percent of patients ¹ with HIV-infection who had a test for Chlamydia within the measurement year.		
Numerator:	Number of HIV-infected patients who received a test for Chlamydia ² in the measurement year	
Denominator:	Number of patients with HIV-infection who had a medical visit with a provider with prescribing privileges ³ at least twice in the measurement year	
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patient refusal of test, documented in medical record 2. Patients who are <18 yrs of age⁴ and deny a history of sexual activity 	
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-positive? (Y/N) <ol style="list-style-type: none"> a. If yes, is the patient > 18 years or sexually active? (Y/N) <ol style="list-style-type: none"> i. If yes, was the patient tested for Chlamydia during the reporting period? (Y/N) 	
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic • Medical record data abstraction by grantee of a sample of records. 	
National Goals, Targets, or Benchmarks for Comparison:	OAPP TFC: 90% None available at this time.	
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Incidence of Chlamydia in the clinic population ○ Incidence of pelvic inflammatory disease in the clinic population 	
Basis for Selection and Placement in HAB Group 3:		
<p>Early detection and treatment of STDs may reduce the risk for STD and HIV transmission. Providers should screen for STD's to treat infections and decrease HIV transmission to sexual partners. Many STD's increase the number of HIV-infected white blood cells in the genital area and increase the risk of transmitting HIV-infection.⁵ STD's can also enhance the risk of transmitting HIV by increasing the viral burden in genital secretions.^{6,7}</p> <p>STD infections in seronegative partners increase the risk for acquiring HIV because they increase of 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.⁸ Susceptibility to transmission may therefore be enhanced. Chlamydia infection in women may often be asymptomatic but like other STD's can also increase the risk for HIV transmission and enhance transmission susceptibility. Providers should test women for Chlamydia infection at least annually to treat infections and to decrease the risk of Chlamydia and HIV transmission. Identification and treatment of STD's can reduce the potential for spread of these infections among high-risk groups (i.e., sex or drug-using networks).⁷</p> <p>The measure focuses on similar aspects of care (STD marker) previously captured in measures listed in HAB Groups 1 and 2. There are currently no guidelines that delineate annual testing.</p>		
US Public Health Guidelines:		
<p>“During the first visit, consider testing all patients for urogenital chlamydial infection. 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</p>		

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

asymptomatic persons at higher risk.”⁷

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² Preferred Chlamydia screening test is urine NAAT, however if other sites are needed rectal swabs and cervical swabs with NAAT, or other testing methods with comparable sensitivity/specificity, are also appropriate.

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁴ 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.

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

⁶ 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

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 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.

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

Performance Measure 2.3: Gonorrhea Screen (HAB Group 3)		OPR-Related Measure: N/A
Percent of adult patients ¹ with HIV-infection who had a test for gonorrhea within the measurement year.		
Numerator:	Number of HIV-infected patients who received a test for Gonorrhea ² in the measurement year	
Denominator:	Number of patients with HIV-infection who had a medical visit with a provider with prescribing privileges ³ at least twice in the measurement year	
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patient refusal of test, documented in medical record 2. Patients who are <18 yrs of age⁴ and deny a history of sexual activity 	
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-positive? (Y/N) <ol style="list-style-type: none"> a. If yes, is the patient >18 years or sexually active? (Y/N) <ol style="list-style-type: none"> i. If yes, was the patient screened for gonorrhea during the reporting period? (Y/N) 	
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic • Medical record data abstraction by grantee of a sample of records. 	
National Goals, Targets, or Benchmarks for Comparison:	OAPP TFC: 90% None available at this time.	
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Incidence of gonorrhea in the clinic population ○ Incidence of pelvic inflammatory disease in the clinic population 	
Basis for Selection and Placement in HAB Group 3:		
<p>Early detection and treatment of STDs may reduce the risk for STD and HIV transmission. Providers should screen for STDs to treat infections and decrease HIV transmission to sexual partners. Many STDs increase the number of HIV-infected white blood cells in the genital area and increase the risk of transmitting HIV-infection.⁵ STDs can also enhance the risk of transmitting HIV by increasing the viral burden in genital secretions.⁶</p> <p>STD infections 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> <p>Identification and treatment of STDs can reduce the potential for spread of these infections among high-risk groups (i.e., sex or drug-using networks.⁷ There are currently no guidelines that delineate annual testing.</p>		
US Public Health Guidelines:		
<p>“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.”⁸</p>		
References/Notes:		
¹ “Patients” include all patients aged 13 years or older.		

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

² Preferred gonorrhea screening test is urine NAAT, however if other sites are needed rectal swabs and cervical swabs with NAAT, or other testing methods with comparable sensitivity/specificity, are also appropriate.

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 A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

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

⁶ 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

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.

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

Performance Measure 2.4: Substance Use Assessment (HAB Group 3)		OPR-Related Measure: #8		
Percentage of patients ¹ with HIV-infection who have been assessed for substance use (alcohol and illicit substances) in the measurement year.				
Numerator:	Number of patients with HIV-infection who were assessed for substance use ² within the measurement year			
Denominator:	Number of patients with HIV-infection who had a medical visit with a provider with prescribing privileges ³ at least twice in the measurement year			
Patient Exclusions:	None			
Data Element:	1. Is the patient HIV-positive? (Y/N) a. If yes, was the patient assessed for substance use during the reporting period with documentation in medical 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. ○ HIVQUAL reports on this measure for grantee under review ○ Medical record data abstraction by grantee of a sample of records. 			
National Goals, Targets, or Benchmarks for Comparison:	OAPP TFC: 90%			
	IHI Goal: 90% ^{4,5}			
	National HIVQUAL Performance Data: ⁴			
		2003	2004	2005
	Top 10%	100%	100%	100%
	Top 25%	92.3%	100%	100%
	Median*	74.4%	86.4%	92.7%
	*from HAB data base			
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 HAB Group 3:				
Patients living with HIV-infection must often cope with multiple social, psychiatric, and medical issues. It is important to identify co-morbid illness such as substance use, which may complicate ongoing HIV treatment.				
US Public Health Guidelines:				
“The chronic and relapsing nature of substance abuse as a biologic and medical disease, compounded by the high rate of mental illness, additionally complicates the relationship between health care workers and IDU. The first step in provision of care and treatment for these individuals is the recognition of the existence of a substance abuse problem. Whereas this is often open and obvious, patients may hide such behaviors from clinicians. Assessment of the patient for the presence of substance abuse should be part of routine medical history taking and should be done in a clinical, straightforward, and nonjudgmental manner” ⁶				
References/Notes:				
¹ “Patients” include all patients aged 13 years or older.				
² Substance abuse assessment: prior history of substance use and abuse, prior substance abuse treatment,				

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

current use/abuse of substances. If patient has no history of substance abuse, annual monitoring for changes in substance use patterns is indicated.

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

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

<http://www.ihl.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientsPatientsAssessedforSubstanceUseandorTobaccoUseinthePast12Months.htm>.

⁵ <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.

⁶ 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. November 3, 2008. Available at <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

DRAFT

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

Performance Measure 2.5: Mental Health Assessment (HAB Group 3)		OPR-Related Measure: #9																	
Percentage of patients ¹ with HIV-infection who have had a mental health assessment.																			
Numerator:	Number of patients who received a mental health assessment ² in the measurement year																		
Denominator:	Number of patients who had a medical visit with a provider with prescribing privileges ³ at least twice in the measurement year																		
Patient Exclusions:	None																		
Data Element:	1. Is the patient HIV-positive? (Y/N) a. If yes, did the patient receive a mental health assessment during the reporting period? (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. 																		
National Goals, Targets, or Benchmarks for Comparison:	<p>OAPP TFC: 90%</p> <p>National HIVQUAL Data:⁴</p> <table border="1"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>100%</td> <td>100%</td> <td>80.6%</td> </tr> <tr> <td>Top 25%</td> <td>93.0%</td> <td>89.5%</td> <td>35.1%</td> </tr> <tr> <td>Median*</td> <td>72.9%</td> <td>66.7%</td> <td>2.2%</td> </tr> </tbody> </table> <p>*from HAB data base</p>				2003	2004	2005	Top 10%	100%	100%	80.6%	Top 25%	93.0%	89.5%	35.1%	Median*	72.9%	66.7%	2.2%
	2003	2004	2005																
Top 10%	100%	100%	80.6%																
Top 25%	93.0%	89.5%	35.1%																
Median*	72.9%	66.7%	2.2%																
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 HAB Group 3:																			
Patients living with HIV-infection must often cope with multiple social, psychiatric, and medical issues. Mental health is an important predictor of ART adherence, and therefore may play a substantial role in a patient’s ability to attain viral suppression on HIV medication. ⁵																			
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 alter outcomes. Once evaluated, these factors should be managed accordingly.” ⁶																			
References/Notes:																			
<p>¹“Patients” include all patients aged 13 years or older.</p> <p>² Mental health screen: documentation of prior mental illness, prior treatment of mental illness, documentation of any current mental health symptoms. If patient has no history of prior mental illness, annual monitoring for symptoms of mental illness (i.e. depression/anxiety) is indicated.</p> <p>³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.</p>																			

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

⁴ <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.
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)

⁵ Mellins CA, Havens JF, McDonnell C, et. al AIDS Care. 2009 Feb;21(2):168-77.

⁶ 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. November 3, 2008. Available at <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

DRAFT

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

Performance Measure 2.6: Hepatitis B Status (HAB Group 3)		OPR-Related Measure: #6
Percentage of patients ¹ with HIV-infection who have ever been tested for Hepatitis B status.		
Numerator:	Number of patients who have documentation of Hepatitis B status ² in the medical record	
Denominator:	Number of patients who had a medical visit with a provider with prescribing privileges ³ at least twice in the measurement year	
Patient Exclusions:	1. Patient refusal of test	
Data Element:	1. Is the patient HIV-positive? (Y/N) a. If yes, is their documentation of Hepatitis B serologic status in the medical 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. 	
National Goals, Targets, or Benchmarks for Comparison:	OAPP TFC: 90% None available at this time.	
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Incidence of Hepatitis B in clinic population ○ Hepatitis B-related morbidity and mortality in the clinic population 	
Basis for Selection and Placement in HAB 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. Although up to 90% of HIV-1–infected persons have at least one serum marker of previous exposure to HBV, only 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 six months.⁴</p> <p>HIV-1 infection is associated with an increased risk for the development of chronic Hepatitis B after HBV exposure. Limited data indicate that co-infected patients with chronic Hepatitis B infection have higher HBV DNA levels and are more likely to have detectable Hepatitis B e antigen (HBeAg), accelerated loss of protective hepatitis B surface antibody (anti-HBs), and increased risk for liver-related mortality and morbidity.⁴</p> <p>Co-infection with HIV and HBV can complicate the care and treatment of HIV, and guide the selection of medications for ART. The measure focuses on similar aspects of care (HCV) previously captured in measures listed in HAB Group 1.</p>		
US Public Health Guidelines:		
<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 co-infection. 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</p>		

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

of any possible HBV treatment. For patients who are HBV negative, prophylaxis is recommended. This consists [of] 3 doses of vaccine for “all susceptible patients (i.e., antihepatitis B core antigen-negative).”^{4,5}

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² Serologic tests to evaluate for Hepatitis B immunity and chronic Hepatitis B include:

- Hep B Surface Antigen (+/-)
- Hep B Surface Antibody (+/-)
- Additional markers: Hep B Core Antibody (IgG or IgM), Hep B e Antigen

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁴ Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.

<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

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. November 3, 2008. Available at <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

Performance Measure 2.7: Hepatitis B Vaccination (HAB Group 2)		OPR-Related Measure: Yes www.hrsa.gov/performance/measure/2.7.htm
Percentage of patients ¹ with HIV-infection who completed the vaccination series for Hepatitis B.		
Numerator:	Number of HIV-infected patients with documentation of having ever completed the vaccination series for Hepatitis B ^{2,3}	
Denominator:	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges ⁴ at least twice in the measurement year	
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patients newly enrolled in care during the measurement year 2. Patients with evidence of current HBV infection (Hep B Surface Antigen, Hep B e Antigen, Hep B e Antibody, or Hep B DNA) 3. Patients with evidence of past HBV immunity (Hep B Surface Antibody) 4. Patients with documented refusal of Hepatitis B vaccine in medical record 	
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, does the patient have documentation of Hepatitis B immunity or HBV-infection? (Y/N) <ol style="list-style-type: none"> i. If no, is there documentation that the patient has completed the vaccine series for Hepatitis B?(Y/N) ii. Documentation includes dated records (e.g., personal, school, physician, or immunization registry) as evidence of vaccination, or documentation of administration of vaccine dose(s) in medical record, or combination of outside records and medical records to achieve three doses of vaccine 	
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 	
National Goals, Targets, or Benchmarks for Comparison:	<p>OAPP TFC = 90%</p> <p>Published data from the HIV Outpatient Study (HOPS) reports 17% of patients with HIV-infection who were eligible for vaccination received at least three doses of vaccine.⁵</p> <p>“Hepatitis B vaccination coverage among adults at high risk...[was] 45% in 2004.”⁶</p>	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> ○ Incidence of Hepatitis B infection in the clinic population 	
Basis for Selection and Placement in HAB Group 2:		
<p>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. Although up to 90% of HIV-1–infected persons have at least one serum marker of previous exposure to HBV, only approximately 10% have chronic Hepatitis B, as evidenced by the detection of HBsAg in the serum persisting for a minimum of six months.³</p> <p>HIV-1 infection is associated with an increased risk for the development of chronic Hepatitis B after HBV exposure. Limited data indicate that co-infected patients with chronic Hepatitis B infection have higher HBV DNA levels and are more likely to have detectable HBeAg, accelerated loss of anti-HBs, and an increased risk for liver-related mortality and morbidity.^{3,7}</p> <p>There is a protective antibody response in approximately 30% to 55% of healthy adults aged ≤40 years after the first dose of vaccine. After age 40, the proportion of persons with a protective antibody</p>		

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

response after a three-dose vaccination regimen declines. In addition to age, other host factors (e.g., smoking, obesity, genetic factors, and immune suppression) contribute to decreased vaccine response. Response to Hepatitis B vaccination also is reduced in other immunocompromised persons (e.g., HIV-infected persons, hematopoietic stem-cell transplant recipients, and patients undergoing chemotherapy). Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting its use.

US Public Health Guidelines:

“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 co-infection. Therefore, providers should know the HBV status of all patients with HIV. For patients who are HBV negative, prophylaxis is recommended. This consists [of] 3 doses of vaccine for “all susceptible patients (i.e., antihepatitis B core antigen-negative).”³

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² Patients in the middle of the vaccination series on 12/31/x would not be captured in the numerator in year x. They would, if the series was completed on schedule, be captured in year x+1.

³ Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.

<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

⁴ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁵ Tedaldi EM, Baker RK, Moorman AC, Wood KC, Fuhrer J, McCabe RE, Holmberg SD; HIV Outpatient Study (HOPS) Investigators. Hepatitis A and B vaccination practices for ambulatory patients infected with HIV. *Clinical Infectious Diseases*. 2004 May 15;38(10):1478-84.

(<http://www.journals.uchicago.edu/CID/journal/issues/v38n10/32448/32448.web.pdf>)

⁶ Centers for Disease Control and Prevention. Hepatitis B Vaccination Coverage Among Adults — United States, 2004. MMWR 2006;55:509-11 (<http://www.cdc.gov/mmwr/PDF/wk/mm5518.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. November 3, 2008. Available at <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

Performance Measure 2.8: Toxoplasmosis screen (HAB Group 3)		OPR-Related Measure: N/A
Percent of patients ¹ with HIV-infection who ever received screening for <i>Toxoplasma gondii</i>		
Numerator:	Number of HIV-infected patients who have documented Toxoplasma status in medical record	
Denominator:	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges ² at least twice in the measurement year	
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patients with known toxoplasmosis (i.e. <i>T. gondii</i> encephalitis) 2. Patient refusal of test 	
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-positive? (Y/N) <ol style="list-style-type: none"> a. If yes, is there documentation of patient's Toxoplasma status in the medical record (Toxoplasma IgG antibody)? (Y/N) 	
Data Sources:	<ul style="list-style-type: none"> o Electronic Medical Record/Electronic Health Record o CAREWare, Lab Tracker, or other electronic o Medical record data abstraction by grantee of a sample of records. 	
National Goals, Targets, or Benchmarks for Comparison:	OAPP TFC: 90% None available at this time	
Outcome Measures for Consideration	<ul style="list-style-type: none"> o Toxoplasmosis-related mortality rates in the clinic population o Incidence of Toxoplasmosis in the clinic population 	
Basis for Selection and Placement in HAB Group 3:		
<p>Clinical disease is rare among patients with CD4 counts >200 cells/mm³. The greatest risk is among patients with a CD4 cell count < 50/uL. HIV-infected patients with TE are almost uniformly seropositive for antitoxoplasma IgG antibodies.²</p> <p>The measure overlaps and focuses on similar aspects of care (prophylaxis) previously captured in measures listed in HAB Group 1.</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> (BIII)”³</p> <p>“Toxoplasma-seronegative persons who are not taking a PCP prophylactic regimen known to be active against TE should be retested for IgG antibody to Toxoplasma when their CD4 T lymphocyte counts decline to <100/uL to determine whether they have seroconverted and are therefore at risk for TE (CIII)”³</p>		
References/Notes:		
<p>¹“Patients” include all patients aged 13 years or older.</p> <p>² A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.</p> <p>³ Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America.</p>		

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

MMWR. March 24, 2009. Volume 58.

<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

DRAFT

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

Performance Measure 2.9: Hepatitis A Vaccination		OPR-Related Measure: N/A
Percentage of patients ¹ with HIV-infection who have received complete dosing regimen (two doses) against Hepatitis A.		
Numerator:	Number of HIV-infected patients who ever completed the vaccination series for Hepatitis A	
Denominator:	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges ² at least twice in the measurement year	
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patients newly enrolled in measurement year 2. Patients with documented immunity to Hepatitis A (Hepatitis A IgG Antibody) 3. Patients with documented refusal of Hepatitis A vaccination 4. Patients with hypersensitivity to Hepatitis A vaccine or its components 	
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-positive? (Y/N) <ol style="list-style-type: none"> a. If yes, is their documentation that the patient has completed the regimen (two doses) for Hepatitis A virus in the medical record? (Y/N) b. Includes dated records (e.g., personal, school, physician, or immunization registry) as evidence of vaccination, or documentation of administration of Hepatitis A vaccine dose(s) in medical record, or combination of outside records and medical records to achieve two doses of Hepatitis A vaccine. 	
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 	
National Goals, Targets, or Benchmarks for Comparison:	<p>OAPP TFC = 90%</p> <p>None available at this time</p>	
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Incidence of acute Hepatitis A infection in clinic population 	
Basis for Selection and Placement in HAB Draft Group 3:		
<p>Between 1980 and 1995, approximately 22,000 to 36,000 cases of hepatitis A were reported annually in the United States, representing an average of 271,000 infections per year.³</p> <p>As with other individuals infected with hepatitis B and C, HIV-infected patients are at risk of decompensation of their underlying liver disease if they encounter hepatitis A. The US PHS, Infection Disease Society of America (IDSA), and Advisory Committee on Immunization Practices (ACIP) guidelines recommend immunization of all susceptible HIV-infected patients who have chronic liver disease or are at increased risk for hepatitis A infection.^{3,4} These patients include:</p> <ul style="list-style-type: none"> • Patients with chronic hepatitis B or C • Injection drug users • MSM • Hemophiliacs <p>The measure overlaps and focuses on similar aspects of care (vaccination) previously captured in</p>		

**HIV MOP Clinical Performance Measures
 for Adult / Adolescent Patients:
 Supplemental Measures**

measures listed in HAB Groups 1 and 2.

US Public Health Guidelines:

“Because fulminant hepatic failure from hepatitis A virus (HAV) infection occurs at increased frequency in person with chronic liver disease, persons susceptible to HAV should receive two doses of HAV vaccine (BIII). HAV vaccine should be administered before the CD4 T-lymphocyte count declines to 200 cells/uL because the response will probably be better.”⁴
 “All patients with HBV should receive hepatitis A vaccine, if found not be immune at baseline (i.e. absence of hepatitis A antibody)”⁵

References/Notes:

- ¹“Patients” include all patients aged 13 years or older.
- ² A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.
- ³ Centers for Disease Control and Prevention. Prevention of hepatitis A through active or passive immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR 2006;55(No. RR-07). <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5507a1.htm>.”
 Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.
<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.
- 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. November 3, 2008. Available at <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

Performance Measure 2.10: Pneumococcal Vaccination (HAB Group 3)		OPR-Related Measure: N/A													
Percentage of patients ¹ with HIV-infection who have ever received a pneumococcal vaccination.															
Numerator:	Number of patients who ever received a pneumococcal vaccination														
Denominator:	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges ² at least twice in the measurement year														
Patient Exclusion:	<ol style="list-style-type: none"> 1. Patients with documented refusal of pneumococcal vaccine 2. Patients with hypersensitivity to pneumococcal vaccine or its components 														
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-positive? (Y/N) <ol style="list-style-type: none"> a. If yes, is there documentation in the chart that the patient received the pneumococcal vaccine within the past five years? (Y/N) b. Includes dated records (e.g., personal, school, physician, or immunization registry) as evidence of vaccination, or documentation of administration of pneumococcal vaccine in medical record in past five years 														
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 														
National Goals, Targets, or Benchmarks for Comparison:	<p>OAPP TFC: 90%</p> <p>National HIVQUAL Data:³</p> <table border="1"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>97.7%</td> <td>95.8%</td> <td>97.5%</td> </tr> <tr> <td>Top 25%</td> <td>92.4%</td> <td>90.1%</td> <td>93.0%</td> </tr> </tbody> </table> <p>*from HAB data base</p>				2003	2004	2005	Top 10%	97.7%	95.8%	97.5%	Top 25%	92.4%	90.1%	93.0%
	2003	2004	2005												
Top 10%	97.7%	95.8%	97.5%												
Top 25%	92.4%	90.1%	93.0%												
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Incidence of pneumococcal infection in clinical population 														
Basis for Selection and Placement in HAB Group 3:															
<p>Bacterial pneumonia is a common cause of HIV-1 related morbidity. Incidence of approximately 100 cases per 1,000 HIV-1 infected persons per year have been reported, a rate much higher than in the non-infected population. The most consistent predictor of bacterial infections is CD4 cell count.⁴</p> <p>The measure overlaps and focuses on similar aspects of care (vaccination) previously captured in measures listed in HAB Group 2.</p>															
US Public Health Guidelines:															
<p>“Adults and adolescents who have a CD4+ T-lymphocyte count of > 200 cells/uL should be administered a single does of 23-valent polysaccharide pneumococcal vaccine (PPV) if they have not received this vaccine during the previous five years (BII)”. Revaccination can be considered for patients who were initially immunized when their CD4+ T-lymphocyte counts were < 200 cells/uL in response to ART (CII).⁵</p> <p>“If earlier vaccination status is unknown, patients in this group [immunocompromised, including HIV] should be administered pneumococcal vaccine.”⁶</p>															
References/Notes:															
¹ “Patients” include all patients aged 13 years or older.															

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

² A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

³ <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.

⁴ Centers for Disease Control and Prevention. Treating opportunistic infections among HIV-infected adults and adolescents: recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association/Infectious Diseases Society of America. MMWR 2004;53(No. RR-15).

⁵ Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.

<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

⁶ Centers for Disease Control and Prevention. Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP) – MMWR April 4, 1997, Vol 46, No. RR-8.

DRAFT

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

Performance Measure 2.11: Influenza Vaccination (HAB Group 3)		OPR-Related Measure: N/A
Number of HIV-infected patients ¹ who received influenza vaccination within the measurement period ² .		
Numerator:	Number of HIV-infected patients who received influenza vaccination within the measurement period	
Denominator:	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges ³ at least twice in the measurement period	
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patient refusal of influenza vaccine documented in the chart 2. Hypersensitivity to influenza vaccine or allergy to its components including thimerosal, chicken protein, and egg protein 3. Previous diagnosis of Guillain-Barre Syndrome 	
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-infected? (Y/N) 2. If yes, is there documentation in the chart that the patient received influenza vaccine in the past 12 months? (Y/N) <ol style="list-style-type: none"> a. Includes dated records (e.g., personal, school, physician, or immunization registry) as evidence of vaccination, or documentation of administration of Influenza vaccine in medical record in measurement year 	
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 	
National Goals, Targets, or Benchmarks for Comparison:	OAPP TFC: 90% None available at this time	
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Mortality rates from influenza and pneumonia in the clinical population 	
Basis for Selection and Placement in HAB 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 two years, and persons of any age who have medical conditions that place them at increased risk for complications of influenza, including HIV.⁴</p> <p>Influenza vaccination is the primary method for preventing influenza and its severe complications.⁴ 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.³</p> <p>The measure overlaps and focuses on similar aspects of care (vaccination) previously captured in measures listed in HAB Group 2. Given the timeframe involved, the data collection process is complicated.</p>		
US Public Health Guidelines:		
“As indicated in this report from the Advisory Committee on Immunization Practices (ACIP), annual influenza vaccination is now recommended for...adults and children who have required regular medical		

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

follow-up or hospitalization during the preceding year because of ...immunodeficiency (including...human immunodeficiency virus).”⁴

“Because influenza can result in serious illness and because vaccination with inactivated influenza vaccine might result in the production of protective antibody titers, vaccination might benefit HIV-infected persons, including HIV-infected pregnant women. Therefore, influenza vaccination is recommended.”⁴

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² Due to the unique nature of this measure and Influenza season/vaccine administration, 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 ART, i.e. MD, PA, NP.

⁴ Centers for Disease Control and Prevention. Prevention and Control of Influenza: Recommendations from the Advisory committee on Immunization Practices (ACIP). MMWR 6006; 55(early release); pp 1-41.

DRAFT

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

Performance Measure 2.12: Hepatitis /HIV Alcohol Counseling (HAB Group 3)		OPR-Related Measure: N/A
Percentage of patients ¹ with HIV and Hepatitis B (HBV) or Hepatitis C (HCV) infection who received alcohol counseling within the measurement year.		
Numerator:	Number of HIV-infected patients who are co-infected with HBV ² or HCV who received alcohol counseling within the measurement year	
Denominator:	Number of HIV-infected patients who <ul style="list-style-type: none"> • Are co-infected with HBV or HCV • had a medical visit with a provider with prescribing privileges³ twice within the measurement year 	
Patient Exclusions	None	
Data Element:	1. Is the patient HIV-positive? (Y/N) <ul style="list-style-type: none"> a. If yes, is the patient HBV or HCV-positive? (Y/N) <ul style="list-style-type: none"> i. If yes, did the patient receive alcohol counseling that was documented in the medical record during the reporting period? (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 	
National Goals, Targets, or Benchmarks for Comparison:	OAPP TFC: 90% None available at this time.	
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Hepatitis-related mortality rates in the clinical population 	
Basis for Selection and Placement in HAB Group 3:		
<p>Discussion of substance use allows the clinician to 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 comorbidity and anemia. It also concluded that alcohol problems are often missed by providers thus increasing the need for routine screening.⁴</p> <p>Long-term studies of patients with chronic HCV infection show that between 2% to 20% develop cirrhosis in 20 years. This rate of progression increases with older age, alcoholism, and HIV-infection.⁴ The definition of “counseling” varies considerably, which impacts the feasibility of data collection.</p>		
US Public Health Guidelines:		
“All patients with HIV/HCV infection should be advised to avoid or limit alcohol consumption...” ⁵		
References/Notes:		
¹ “Patients” include all patients aged 13 years or 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		

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁴ 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? JAIDS Journal of Acquired Immune Deficiency Syndromes 33:521–525.

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. November 3, 2008. Available at <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

DRAFT

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

Performance Measure 2.13: Tobacco Cessation (HAB Group 3)		OPR-Related Measure: N/A																	
Percentage of patients ¹ with HIV-infection who received tobacco cessation counseling within the measurement year.																			
Numerator:	Number of HIV-infected patients who received tobacco cessation counseling within the measurement year																		
Denominator:	Number of HIV-infected patients 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 twice within the measurement year 																		
Patient Exclusions:	1. Patients who deny tobacco use throughout the measurement year																		
Data Element:	1. Is the patient HIV-positive? (Y/N) <ol style="list-style-type: none"> a. If yes, did the patient use tobacco during the reporting period? (Y/N) <ol style="list-style-type: none"> i. If yes, did the patient receive tobacco cessation counseling documented in the medical record during the reporting period? (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 																		
National Goals, Targets, or Benchmarks for Comparison:	OAPP TFC: 90% National HIVQUAL Data: ³ <table border="1" data-bbox="381 1092 971 1249"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> </tr> </thead> <tbody> <tr> <td>Top 10%</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> </tr> <tr> <td>Median*</td> <td>75.8%</td> <td>90.0%</td> <td>88.2%</td> </tr> </tbody> </table> *from HAB data base				2003	2004	2005	Top 10%	100%	100%	100%	Top 25%	93.3%	97.8%	98.4%	Median*	75.8%	90.0%	88.2%
	2003	2004	2005																
Top 10%	100%	100%	100%																
Top 25%	93.3%	97.8%	98.4%																
Median*	75.8%	90.0%	88.2%																
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Rate of head and neck, and lung cancer ○ Rate of tobacco use in the clinical population 																		
Basis for Selection and Placement in HAB Group 3:																			
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 rates ⁵ 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.																			
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 “Patients” include all patients aged 13 years or older.																			

**HIV MOP Clinical Performance Measures
for Adult / Adolescent Patients:
Supplemental Measures**

² A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

³ <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>

⁴ Phillips, Abstract #8, CROI, Boston, MA 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.

DRAFT