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Performance Measure:

Waiting Time for Initial Access to Outpatient/Ambulatory Medical Care

National Quality Forum #: None

Description: 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 care¹

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 care¹

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 Elements:

For each agency:

1. Is the organization funded by the Ryan White Program to provide outpatient/ambulatory medical care? (Y/N)
 - 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?
 - i. Is the third next available appointment < 15 business days? (Y/N)

For the system:

1. How many outpatient/ambulatory medical care organizations are funded by the Ryan White Program to provide outpatient/ambulatory medical care?
 - a. Of those organizations, how many have < 15 business days for the third next available appointment to enroll in outpatient/ambulatory medical care?

Data Sources: 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.)



Example:

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?”

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.

Results of System A Point in Time Survey:

Date of data collection: September 14, 2018 (N=6)

Agency 1: The 1st available appointment was on 9/14/2018 the wait time was 0 (zero) days. The 2nd available appointment was scheduled on 9/23/18 and with a wait time of 7 days. The 3rd available appointment was 10/15/18 and with a wait time of 23 days. The appointments on 9/14/2018 and 9/23/2018 were within the 15 day appointment window. All of the appointments except for the 10/15/2018 appointment meet the standard of patients having a waiting time of 15 business days or less to receive an appointment to enroll in ambulatory/outpatient care.

Agency 2: The 1st available appointment was 9/14/2018 the wait time was 0 (zero) days. The 2nd available appointment was also 9/14/2018* the wait time for the appointment is the same as the 1st appointment, 0 (zero) days. The 3rd available appointment is also 9/14/2018, with a wait time of 0 (zero) days. All of the appointments are compliant with the measure regarding a patient having a wait time of 15 business days or less to receive an appointment to enroll in ambulatory/outpatient care.

Agency 3: The 1st available appointment was 11/24/2018, with a wait time of 50 days. The 2nd available appointment was 12/15/2018, with a wait time of 64 days. The 3rd available appointment was 1/19/2019, with a wait time of 88 days. None of the appointments met the criteria of a patient receiving an appointment within 15 business days or less for an eligible patient to receive an appointment to enroll in ambulatory/outpatient medical care.



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Agency 4: The 1st available appointment was 9/21/2018 the wait time was 5 days. The 2nd available appointment was 9/21/2018, the wait time was also 5 days. The 3rd available appointment was also 9/21/2018, the wait time was 5 days. All of the appointments are compliant with the measure regarding a patient having a wait time of 15 business days or less to receive an appointment to enroll in ambulatory/outpatient care.

Agency 5: The 1st appointment was None. The 2nd available appointment was None. The 3rd available appointment was None. None of the patients were seen because the agency was not accepting new patients at the time.

Agency 6: The 1st appointment was 9/14/2018, with a wait time of 0 (zero) days. The 2nd available appointment was 9/17/2018, with a wait time of 3 days. The 3rd available appointment was 9/20/2018, with a wait time of 4 days. All of the appointments are compliant with the measure regarding a patient having a wait time of 15 days business days or less to receive an appointment to enroll in ambulatory/outpatient care.

*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].)

The numbers below depicts the percentage of agencies meeting the performance measure over three quarters.

Example: Performance measure rates for Quarters 1 through 3 are listed below:



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- Quarter 1= 52%
- Quarter 2= 72%
- Quarter 3= 50%

National Goals, Target, or Benchmarks for Comparison: None

Outcome Measures for Consideration:

- Percent of patients who are retained in outpatient/ambulatory medical care in the measurement year
- Percent of patients diagnosed with Pneumocystis jiroveci (PCP) in the measurement year

Basis for Selection:

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

U. S. Public Health Service Guidelines: None

References/Notes:

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 appointments 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 National Quality Measures Clearinghouse, “Access: time to third next available appointment for an office visit”. <https://innovations.ahrq.gov/qualitytools/national-quality-measures-clearinghouse-nqmc> Available online. Accessed April 2019.



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³ Mugavero MJ, Lin HY, Alison JJ, et al. Failure to Establish HIV Care: Characterizing the “No Show” Phenomenon. *Clinical Infectious Diseases*. 2007; 45:127-130.



Performance Measure: HIV Test Results for PLWHA

National Quality Forum #: None

Description: Percentage of individuals who test positive¹ 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 positive¹ 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 positive¹ for HIV in the measurement year.

Patient Exclusions:

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 positive confirmatory test (i.e., confirmatory test at first medical care visit)
4. Patients who are less than 13 years of age

Data Elements:

For each agency:

1. Was the patient tested for HIV infection during the measurement year? (Y/N)
 - a. If yes, did the patient have a positive confirmatory test¹? (Y/N)
 - i. If yes, was the patient given his/her confirmatory test result in the measurement year? (Y/N)

For the system:

1. How many patients were tested for HIV infection within the system/network in the measurement year?
 - a. How many patients had positive confirmatory tests?
 - i. Of those patients, how many received the confirmatory test results?

Data Sources:

- 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

Outcome Measures for Consideration:

- 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

U.S. 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



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References/Notes:

- ¹ “Test positive” includes only a confirmatory HIV test, regardless of the test used.
- ² Centers for Disease Control and Prevention. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. [MMWR 2006:55](#) [MMWR Recommendations and Reports: Past Volume \(2006\)](#) (No. RR-14):1-17 Accessed April 2019.
- ³ “Ryan White HIV/AIDS Treatment Extension Act of 2009”. (P.L. 111-87), 42 USC 201. [TITLE XXVI—HIV HEALTH CARE SERVICES PROGRAM](#)



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Performance Measure: HIV Positivity

National Quality Forum#: None

Description: Percentage of HIV positive tests in the measurement year

Numerator: Number of HIV positive tests in the 12-month measurement period

Denominator: Number of HIV tests conducted in the 12-month measurement period

Patient Exclusions: None

Data Elements:

1. Number of HIV tests conducted in the measurement year
 - i. Of the number of HIV tests conducted, number that were HIV positive

Comparison Data: None

U.S. Department of Health and Human Services Guidelines: None Available

Use in Other Federal Programs:

U.S. Department of Health and Human Services HIV measures: <http://blog.aids.gov/SecretarySebeliusApprovesIndicatorsforMonitoringHHS-FundedHIVServices>

References/Notes: None



Performance Measure: Late HIV Diagnosis¹

National Quality Forum #: 1999

Description: Percentage of patients with a diagnosis of Stage 3 HIV (AIDS) within 3 months of diagnosis of HIV

Numerator: Number of persons with a diagnosis of Stage 3 HIV infection (AIDS) within 3 months of diagnosis of HIV infection in the 12- month measurement period

Denominator: Number of persons with an HIV diagnosis in the 12-month measurement period

Patient Exclusions: None

Data Elements:

1. Does the patient receive an initial diagnosis of HIV in the measurement year? (Y/N)
 - a. Did the patient receive a diagnosis of Stage 3 HIV (AIDS) within 3 months of his/her initial diagnosis of HIV? (Y/N)

Comparison Data: None Available

U.S. Department of Health and Human Services Guidelines:

Adult guidelines: ² “Fundamental to earlier initiation of ART recommended in these guidelines is the assumption that HIV will be diagnosed early in the course of the disease. Unfortunately, in some patients, HIV infection is not diagnosed until the later stages of the disease. Despite the recommendations for routine, opt-out HIV screening in the health care setting regardless of perceptions about a patient’s risk of infection and the gradual increase in CD4 counts at first presentation in care, median CD4 count of newly diagnosed patients remains below 350 cells/mm³. Diagnosis of HIV infection is delayed more in nonwhites, those who use injection drugs, and older adults than in other populations, and many individuals in these groups develop AIDS-defining illnesses within 1 year of diagnosis. Therefore, to ensure that the current treatment guidelines have maximum impact, routine HIV screening per current Centers for Disease Control and Prevention recommendations is essential. It is also critical that all patients who receive an HIV diagnosis are educated about HIV disease and linked to care for full evaluation, follow-up, and management as soon as possible. Once patients are in care, focused effort is required to initiate ART and retain them in the health care system so that the individuals with HIV and their sexual partners can fully benefit from early diagnosis and treatment.”

Use in Other Federal Programs:

U.S. Department of Health and Human Services HIV measures: [Secretary Sebelius Approves Indicators for Monitoring HHS-Funded HIV Services](#)



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References/Notes:

¹The HIV/AIDS Bureau did not develop this measure. The Centers for Disease Control and Prevention (CDC) developed this measure. More information is available at: [National Quality Forum](#) (NQF Measure #1999)

²Panel on Antiretroviral Guidelines for Adults and Adolescents. [Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV](#). Department of Health and Human Services. Available online. Section Accessed May 2, 2019. E-3.



Performance Measure: Linkage to HIV Medical Care

National Quality Forum #: None

Description: Percentage of patients, regardless of age, who attended a routine HIV medical care visit within 1 month of HIV diagnosis

Numerator: Number of patients who attended a routine HIV medical care visit within 1 month of HIV diagnosis

Denominator: Number of patients, regardless of age, with an HIV diagnosis in the 12- month measurement year

Patient Exclusions: None

Data Elements:

1. Did the patient, regardless of age, receive a diagnosis of HIV in the measurement year?
(Y/N)
 - a. Did the patient have at least one routine HIV medical care visit within 1 month of a diagnosis of HIV? (Y/N)

Comparison Data:

National HIV/AIDS Strategy: Updated to 2020: Indicator 4: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of diagnosis to at least 85 percent. The NHAS Indicator and Progress for the National HIV/AIDS Strategy: Updated to 2020 located at: <https://www.hiv.gov/federal-response/national-hiv-aids-strategy/nhas-update>. Reports annual performance targets of: 2012 as 71.7%; 2013 as 72.4%; 2014 as 73.9%; 2015 as 75.4% 2016 as 76.9% 2017 as 78.3% 2018 as 80.6% 2019 as 82.8% and 2020 as 85%.

U.S Department of Health and Human Services Guidelines:

¹Recommendations for HIV prevention with adults and adolescents with HIV in the United States, 2014:

“A growing body of evidence indicates that early initiation of HIV medical care and antiretroviral treatment (ART) and sustained high adherence to ART improve health outcomes and survival rates and can prevent HIV transmission¹⁻⁸(see Section 5, Treatment). Starting HIV medical care shortly after diagnosis and sustaining long-term care also provides opportunities to offer risk-reduction interventions, partner services,*sexually transmitted disease (STD) services, and other services to prevent HIV transmission.⁹⁻¹⁹Some studies show that persons who stay in care during their first year of outpatient HIV medical care are more likely to start ART than persons with early lapses in care, have high adherence to ART, achieve virologic suppression, and practice safer sexual behaviors.^{3,7,20,21}”



*Partner services include an array of voluntary services for persons with HIV or STD and their sex and drug-injection partners that are intended to reduce HIV transmission: interviewing persons with HIV to obtain information to contact or locate their sex and drug-injection partners; notifying partners of possible HIV exposure; offering testing for HIV, sexually transmitted diseases, and other infections; providing condoms, prevention information, and counseling; and providing help in obtaining risk-reduction services, HIV medical care, and other medical and social services

1. Cheever LW. Engaging HIV-infected patients in care: their lives depend on it. Clin Infect Dis 2007; 44(11):1500-1502.
2. Cohen MS, et al. Prevention of HIV-1 infection with early antiretroviral therapy. N Engl J Med 2011; 365(6):493-505.
3. Metsch LR, et al. HIV transmission risk behaviors among HIV-infected persons who are successfully linked to care. Clin Infect Dis 2008; 47(4):577-584.
4. Thompson MA, et al. Antiretroviral treatment of adult HIV infection: 2012 recommendations of the International Antiviral Society-USA Panel. JAMA2012; 308(4):387-402.
5. Tripathi A, et al. The impact of retention in early HIV medical care on viro-immunological parameters and survival: a statewide study. AIDS Res Human Retroviruses 2011; 27(7):751-758.
6. Panel on Antiretroviral Guidelines for Adults and Adolescents. [Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV](#). Accessed May 2, 2019.
7. Ulett KB, et al. The therapeutic implications of timely linkage and early retention in HIV care. AIDS Patient Care STDS2009; 23(1):41-49.
8. The White House Office of National AIDS Policy. National HIV/AIDS strategy for the United States. [National HIV/AIDS Strategy: Updated to 2020](#) Accessed May 2, 2019. National HIV/AIDS Strategy for the United States Updated to 2020. [NATIONAL HIV/AIDS STRATEGY for the UNITED STATES](#): Accessed May 2, 2019.
9. Cain LE, et al. When to initiate combined antiretroviral therapy to reduce mortality and AIDS-defining illness in HIV-infected persons in developed countries: an observational study. Ann Intern Med2011; 154(8):509-515.
10. Centers for Disease Control and Prevention. Recommendations for partner services programs for HIV infection, syphilis, gonorrhea, and chlamydial infection. MMWR2008; 57(RR-9):1-83.
11. Centers for Disease Control and Prevention. [Sexually transmitted diseases treatment guidelines, 2015](#). MMWR2015; 64(3).



12. Giordano TP, et al. The population effectiveness of highly active antiretroviral therapy: are good drugs good enough? *Curr HIV/AIDS Rep*2005; 2(4):177-183.
13. HIV Prevention Trials Network. HPTN 052: [a randomized trial to evaluate the effectiveness of antiretroviral therapy plus HIV primary care versus HIV primary care alone to prevent the sexual transmission of HIV-1 in serodiscordant couples](#). 2012. Accessed May 2, 2019.
14. Kitahata MM, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med*2009; 360(18):1815-1826.
15. Marrazzo JM, et al. HIV prevention in clinical care settings: 2014 recommendations of the International Antiviral Society–USA Panel. *JAMA*2014; 312(4):390-409.
16. Sterne JA, et al. Timing of initiation of antiretroviral therapy in AIDS-free HIV-1-infected patients: a collaborative analysis of 18 HIV cohort studies. *Lancet* 2009; 373(9672):1352-1363.
17. U.S. Department of Health and Human Services. [Treating HIV-infected people with antiretrovirals significantly reduces transmission to partners](#). Findings result from NIH-funded international study. *NIH News* 2011. Accessed May 2, 2019.
18. Vernazza PL, et al. Potent antiretroviral treatment of HIV-infection results in suppression of the seminal shedding of HIV. *The Swiss HIV Cohort Study. AIDS*2000; 14(2):117-121.
19. Walensky RP, et al. The survival benefits of AIDS treatment in the United States. *J Infect Dis* 2006; 194(1):11-19.
20. Mugavero MJ, et al. Missed visits and mortality among patients establishing initial outpatient HIV treatment. *Clin Infect Dis* 2009; 48(2):248-256.
21. Giordano TP, et al. Retention in care: a challenge to survival with HIV infection. *Clin Infect Dis* 2007; 44(11):1493-1499.

Use in Other Federal Programs:

[National HIV/AIDS Strategy: Updated to 2020](#) Indicator 4 - Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85 percent.

References/Notes:

¹Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, the National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. [Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014](#). Accessed May 2, 2019.



Performance Measure: Housing Status

National Quality Forum #: None

Description: Percentage of patients who attended a routine HIV medical care visit within 3 months of HIV diagnosis

Numerator: Number of persons with an HIV diagnosis who were homeless or unstably housed in the 12-month measurement period

Denominator: Number of persons with an HIV diagnosis receiving HIV services in the last 12 months

Patient Exclusions: None

Data Elements:

1. Does the patient have a diagnosis of HIV? (Y/N)
 - a. Did the patient have at least one HIV service during the measurement year? (Y/N)
 - i. Was the patient homeless or unstably housed? (Y/N)

Comparison Data: None Available

U.S. Department of Health and Human Services Guidelines:

Adult Guidelines: ¹“Patients living with HIV infection often must cope with many social, psychiatric, and medical issues that are best addressed through a patient-centered, multidisciplinary approach to the disease. The baseline evaluation should include an evaluation of the patient’s readiness for ART, including an assessment of high-risk behaviors, substance abuse, social support, mental illness, comorbidities, economic factors (e.g., unstable housing), medical insurance status and adequacy of coverage, and other factors that are known to impair adherence to ART and increase the risk of HIV transmission. Once evaluated, these factors should be managed accordingly. The baseline evaluation should also include a discussion of risk reduction and disclosure to sexual and/or needle sharing partners, especially with untreated patients who are still at high risk of transmission.”

Use in Other Federal Programs: U.S. Department of Health and Human Services HIV measures: [Secretary Sebelius Approves Indicators for Monitoring HHS-Funded HIV Services](#)

References/Notes:

¹ Panel on Antiretroviral Guidelines for Adults and Adolescents. [Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV](#). Department of Health and Human Services. Section accessed May 3, 2019. B-18.



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