U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

HAB HIV Performance Measures
Core Clinical FAQs

October 2010

The document focuses on questions related to the HIV/AIDS Bureau's core clinical performance measures that are most frequently asked by programs that receive funds under the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White HIV/AIDS Program). FAQs will be updated as necessary.

Questions that relate to the various types of performance measures can be found at: http://www.hab.hrsa.gov/special/habmeasures.htm.

The following categories of questions have been frequently asked and the corresponding answers are detailed in this document:

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Scope of Core Clinical Performance Measures

Question: Are children included in the eligible population for HAB's core clinical performance measures?

Answer: No. Children aged 12 years and younger are not included in the HAB core performance measures. A separate set of measures targeted to children (pediatric performance measures) was released in August 2010 (see http://hab.hrsa.gov/special/habmeasures.htm). Refer to the table "Measure by Target Population" [add link to spreadsheet]

Question: Why aren't general health indicators included in the clinical performance measures?

Answer: National performance measures have been established for a wide range of general health conditions, such as immunizations, prenatal care and screenings. Since there are currently no national consensus performance measures for HIV care, the HAB HIV Core Clinical Performance Measures focus on key elements of care that are pertinent to the HIV-infected patient population served by the Ryan White HIV/AIDS Programs.

Question: Why isn't basic patient education included in the clinical performance measures?

Answer: Patient education is clearly an important element of care that should be integrated into every visit. Patient education permeates the other HAB measures and is redundant as a single measure.

Question: Why isn't Hepatitis A vaccination included in the clinical performance measures?

Answer: According to the CDC guidelines, Hepatitis A vaccination is recommended in persons with chronic liver disease, men who have sex with men and injection drug users. HAV-susceptible, HIV-infected individuals with risk factors for HAV infection should also receive hepatitis A vaccination. The complexity of identifying the population focus limits the utility of the measure.

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Elements of Core Clinical Performance Measures

Question: What constitutes an HIV care setting?

Answer: For the purposes of the HAB performance measures, an HIV care setting is one that receives Ryan White HIV/AIDS Treatment Extension Act of 2009 funding to provide HIV care. Each program receiving these funds is required to implement a quality management program to monitor the quality of care and address needs as appropriate. A systems-level measure has been developed that captures the number of programs within a system or network that have implemented quality management programs (see http://hab.hrsa.gov/special/habmeasures.htm).

Question: What constitutes a medical visit?

Answer: For the purposes of these measures, a medical visit is considered any visit with a health care professional who is certified in their jurisdiction and has prescribing privileges.

Question: Can a lab test be used as a surrogate marker for medical visit?

Answer: Because lab tests do not have to coincide with a medical visit to a provider with prescribing privileges, a lab test cannot be used as a surrogate marker for a medical visit.

Question: Can a phone consultation be counted as a medical visit?

Answer: No, a phone consultation cannot be counted as a medical visit.

Question: What is meant by "HAART"?

Answer: HAART stands for "highly active antiretroviral therapy" and refers to combination antiretroviral therapy that is of sufficient potency to achieve an undetectable viral load in most all cases. Guidelines on HAART can be found at http://www.aidsinfo.nih.gov/.

Question: Why do the performance measures focus on prescribing a treatment rather than offering it to the client? This does not take the patient's right to refuse treatment into consideration.

Answer: It is understood that patients, for many reasons, may choose not to fill or take a prescribed treatment and it is not expected that programs will have attained 100% compliance on the measures. However, it is important for programs to capture the actual percentage of clients that are on a prescribed treatment regimen and identify opportunities for improvement. Often times when programs begin to track and trend data, they find unexpected levels of performance and new opportunities for improvement.

Question: Patients often refuse vaccinations. Why isn't patient refusal considered as an exclusion criteria?

Answer: As with other treatment regimens, some clients will refuse vaccinations. However, clinical data have shown immunizations to be a critical component of care in respect to prevention, care and treatment. It is important for programs to know the degree to which vaccinations, or other standards of care, are being refused. If high rates of refusal are noted this should be further examined as a quality issue. For example, data could be reviewed to identify trends in client refusal, such as patient demographics, geographic distance, stage of illness, etc. Key informant interviews can also provide additional information in regards to reasons for refusal.

Question: What constitutes adherence assessment and counseling and who can provide it?

Answer: Adherence assessment and counseling occur in the context of comprehensive medical care. Anyone on the care team can conduct the assessment or provide counseling as long as appropriate feedback is given to the provider so that treatment changes can be made as necessary. Sessions provided as part of the medical visit can be counted and do not require a separate visit. Assessment of adherence can include patient reports through the use of quantifiable scales, such as missing 9 out of 10 doses, or through qualitative Likert scales which rate a response based on a numeric scale, e.g. 1-5. Assessment can also be made through quantified reviews such as pill counts or pharmacy dispensing records.

Question: What constitutes risk counseling and who can provide it?

Answer: Risk counseling focuses on preventing super-infection of the patient and preventing transmission of HIV to others. Risk counseling includes the assessment of risk, provision of counseling and as necessary, referrals to appropriate resources. As with adherence assessment and

counseling, risk counseling occurs in the context of comprehensive medical care. Anyone on the care team can provide the counseling as long as appropriate feedback is given to the provider so that the treatment plan and approach can be modified as necessary. Sessions provided as part of the medical visit can be counted and do not require a separate visit.

Question: If a woman has had a hysterectomy, should she be screened for cervical cancer?

Answer: The answer depends on the reason for the hysterectomy. If the hysterectomy was performed for non-dysplasia or non-malignant conditions, then a Pap screen does not need to be completed. In these instances, the client would be excluded from the denominator. If, however, the hysterectomy was performed because of dysplasia or cancer, Pap screens should be completed and the client should be included in the denominator.

Question: If a patient has undergone male-to-female transgender surgery, should she be screened for cervical cancer?

Answer: If the glans penis was used to construct the cervix then Pap screens should be completed according to the same schedule recommended for all women.

Question: Does Medicare cover fasting lipid panels?

Answer: There are different rules of coverage, depending on the situation of the patient.

1) Lipid evaluation as a screening test: A patient entitled to Medicare Part B may receive coverage of screening blood tests for the early detection of cardiovascular disease in individuals without signs or symptoms of heart disease and stroke. This Medicare cardiovascular screening benefit includes coverage of the use of three screening blood tests, a total cholesterol, a HDL, cholesterol, and triglycerides tests (performed after a 12-hour fasting period) ordered individually or together as a lipid panel (CPT code 80061). Frequency of coverage is limited to either each individual test or 1 lipid panel every 5 years. If any abnormal value is obtained in performing these screening tests, further testing may be covered under the diagnostic clinical laboratory benefit, if it is ordered by the patient's physician and the local Medicare contractor determines that it is medically necessary for the patient in accordance with the coverage policy on lipid testing as

described in section 190.23 of the Medicare National Coverage Determinations (NCD) Manual.

2) Lipid evaluation to assess for lipid perturbations caused by antiretroviral agents: If the patient is prescribed a medication that may cause lipid perturbations, such as occurs with some antiretroviral agents, the lipid test is not a true "screening" test, but a diagnostic test. In this setting, a lipid panel (CPT code 80061) may be covered by Medicare if the diagnostic code of 272.6 (Lipodystrophy) or V58.69 (Long term [current] use of other medicines) is applicable and used for that visit and the local Medicare contractor determines that such coverage is consistent with the coverage policy on lipid testing as described in section 190.23 of the Medicare NCD Manual.

Question: Why is Hepatitis B screening and vaccination presented as two separate measures?

Answer: Hepatitis B screening and vaccination are important for different reasons. HBV is the leading cause of chronic liver disease worldwide with up to 90% of HIV-infected persons having at least one serum marker. For those infected with HBV, flares in HBV activity can lead to liver-associated complications. In addition, toxicity to ARV therapy can affect the treatment of HIV in co-infected patients. By knowing the patient's HBV status, both diseases can be managed more effectively. For those who are not infected with HBV, vaccination can prevent transmission. Additional information related to hepatitis can be found at www.cdc.gov/hepatitis/HBV.htm.

Question: Within the Hepatitis B vaccination measure are the numerator and denominator measuring two different populations? Why are new patients excluded?

Answer: The measure is designed to capture the percentage of clients who completed the vaccination series, which represents a 3-dose schedule. The denominator represents those clients who were seen in the measurement year and had no documentation of ever having vaccination or documented susceptibility to Hepatitis B. Comparing those who were eligible for the vaccination series (denominator) with those who received the series (numerator), the percentage can be calculated. Clients new to care in the measurement year may have begun the series, but may not have completed the entire course within the defined time period.

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Question: Hepatitis B vaccination is a one-time series for immunization. How will this be monitored over time?

Answer: At the client level, it is important to determine if the client was eligible and had received Hepatitis B vaccination at one point during the client's life. When looking at data over time, the focal point shifts and concentrates on completion rates of the vaccination series for the clinic population as a whole. If the rates of completion are lower than desired, specific points of influence can be explored to have a positive impact and raise the rates. Potential points of influence (or areas for improvement) can be related to the process of notifying the provider of an impending vaccine, reminding clients of appointments to receive the vaccination or patient education about the need and importance of the vaccination. Any one of these areas could have a positive impact on the completion rates of vaccination series.

Question: In regards to Hepatitis B immunization, should patients with isolated anti-HBc be included or excluded in the denominator?

Answer: In certain persons, the only HBV serologic marker detected in serum is anti-HBc and may not be detectable by commercial serology . Therefore, including or excluding patients with isolated anti-HBc depends on the rate of prevalence of Hepatitis B in the clinic population. Some experts recommend persons who are positive only for anti-HBc and who are from a low endemic area with no risk factors for HBV should be given the full series of Hepatitis B vaccine. Re-evaluation is recommended if there is no response after vaccination. Additional information can be found at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5516a1.htm

Question: Dental care is not readily available in many communities. Why is this included as a core clinical performance measure?

Answer: Aggregate data presented by the National HIVQUAL Project indicates approximately one-third of clients receive an annual dental screening. While many primary care providers are not in a position to assure dental care is available, an oral exam performed by a dentist remains a critical part of primary care. It is important to establish the baseline frequency of services being rendered and as a result, have been included in the core clinical performance measures. Such data may help document gaps in care.

Question: What is the difference between an oral exam and dental screening? Can the oral exam be completed by a physician?

Answer: A dental screening can be performed by any trained health care professional and is used to determine whether dental services are required. An oral exam includes a comprehensive examination of hard and soft tissues in the oral cavity and must be completed by a dentist. The focus of this measure is to determine the percentage of clients who receive an annual oral exam, and therefore, must be completed by a dentist. For purposes of this measure, documentation may be based on patient self report or other documentation.

Question: Since toxoplasmosis affects only those clients with CD4 counts <50 cells/mm3, why does it apply to all clients?

Answer: While it is true that clients with CD4 counts <50 cells/mm3 are at greatest risk for developing toxoplasmic disease, the measure focuses on the identification of latent infection, not to prevent illness. Current guidelines recommend all HIV-infected persons be tested for IgG antibody to Toxoplasma soon after the diagnosis of HIV infection and counseled regarding sources of Toxoplasma infection.

Question: Why is urogenital testing the only testing referenced in the chlamydia and gonorrhea measures?

Answer: CDC guidelines recommend considering testing for urogenital chlamydial infection and urogenital gonorrhea on the first visit for all patients. Appropriate medical care would require testing of other sites based on the specific risks. For instance, patients reporting receptive oral sex should be tested for pharyngeal gonococcal infection. Readers are encouraged to review the CDC guidelines to determine the most appropriate testing for their population (http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf).

Question: Why aren't exclusion criteria similar to PCP prophylaxis included in the MAC prophylaxis measure?

Answer: Exclusion criteria are included if a specific issue or event has the potential to significantly impact the data and results. Based on the small number of patients affected by MAC and the smaller subset of patients whose CD4 count rises above 50 cells/mm3 after being repeated three months later, it was determined that exclusion criteria for this situation was not warranted. If, after analyzing the data, this is determined to be a more prevalent issue for your program, grantees may choose to utilize the following exclusion criteria:

Patients with CD4 T-cell counts below 50 cells/mm3 repeated within 3 months rose above 50 cells/mm3.

Question: Why does the substance use measure only focus on newly enrolled clients?

Answer: The purpose of screening newly enrolled clients is to identify past or current problems with substance use that can negatively impact linkage to care and management of their disease. The measure hones in on this aspect of care knowing that additional assistance may be required to effectively link this population to care. This does not imply established clients should not be screened. As part of their ongoing care, all clients should be screened annually for substance use.

Question: Many of the measures reflect aspects of care that require referrals, yet the measures do not address this. Are we expected to follow-up?

Answer: Very few organizations can provide the full range of services needed by our clients. By default, referrals become a necessary part of the continuum of care. As such, it is important that an organization be able to monitor, track and document the outcome of referrals to ensure the care requirements are being met for each client. Tracking of referrals should be integrated into the system of care and policies and procedures should outline the expectations of the referring agency.