HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1

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

Performance Measure: Medical Visits	**OPR-Related Measure:** Yes www.hrsa.gov/performancereview/measures.htm
Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year	
Numerator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges[1], i.e. MD, PA, NP, in an HIV care setting[2] two or more times at least 3 months apart during the measurement year
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year
Patient Exclusions:	1. Patients newly enrolled in care during last six months of the year
Data Element:	1. Is the client HIV-infected? (Y/N) a. Did the client have at least 2 medical visits in an HIV care setting during the reporting period? (Y/N) i. If yes, list the quarters of these visits
Data Sources:	• Ryan White Program Data Report, Section 5, Items 42 and 43 may provide data useful in establishing a baseline for this performance measure • 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	None available at this time.
Outcome Measures for Consideration	° Rate of HIV-related hospitalizations in the measurement year ° Rate of HIV-related emergency room visits in the measurement year ° Rate of opportunistic infections in the measurement year ° Mortality rates
Basis for Selection and Placement in Group 1:	
Clinicians should schedule routine monitoring visits at least every 4 months for all HIV-infected patients who are clinically stable.[3,4] Greater experience among primary care physicians in the care of persons with AIDS improves survival.[5] Measure reflects important aspects of care that significantly impacts mortality. Data collection is currently feasible and measure has a strong evidence base supporting the use.	
US Public Health Service Guidelines:	
In general, patients with early-stage disease are seen at 3-month intervals to undergo routine medical evaluation and monitoring of CD4 T-cell count, viral load and CBC. During the initial evaluation more frequent visits are common because there is so much information to transmit. Visits should also be more frequent when therapy is introduced and when the CD4 T-cell count is <200 cells/mm^3 because complications	

are more likely.[6]

Multiple studies have demonstrated that better outcomes are achieved in patients cared for by a clinician with expertise. This has been shown in terms of mortality, rate of hospitalizations, compliance with guidelines, cost of care, and adherence to medications. The definition of expertise in these studies has varied, but most rely on the number of patients actively managed. Based on this observation, the Panel recommends HIV primary care by a clinician with at least 20 HIV-infected patients and preferably at least 50 HIV-infected patients. Many authoritative groups have combined the recommendation based on active patients, along with fulfilling ongoing CME requirements on HIV-related topics.[7]

References/Notes:

Guidelines state that routine monitoring of HIV-infected patients should occur at least every 3-4 months depending on the stage of the disease.[7] The timeframe of 6 months was determined by clinical expert consensus for the purpose of this measure, but CD4 T-cell counts can and should be measured at more frequent intervals if needed.

[1]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.

[2]An HIV care setting is one which received Ryan White HIV/AIDS Treatment Modernization Act of 2006 funding to provide HIV care and has a quality management program in place to monitor the quality of care addressing gaps in quality of HIV care.

[3]New York State Department of Health. Primary care approach to the HIV-infected patient. New York: New York State Department of Health; 2004. p. 8. http://www.hivguideliens.org/Content.aspx?pageID=257[Accessed November 27, 2007].

[4]AETC National Resource Center. Clinical Manual for Management of the HIV-Infected Adult http://www.aidsetc.org/pdf/AETC-CM_071007.pdf [Accessed November 27, 2007].

[5]Kitahata MM, Van Rompaey SE, Dillingham PW, Koepsell TD, Deyo RA, Dodge W, Wagner EH. Primary care delivery is associated with greater physician experience and improved survival among persons with AIDS. J Gen Intern Med. 2003 Feb;18(2):157-8.

[6]Bartlett JG, Cheever LW, Johnson MP, Paauw DS [eds]. A Guide to Primary Care of People with HIV/AIDS. Rockville(MD): US Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau; 2004, p. 167. http://hab.hrsa.gov/tools/primarycareguide/. [Accessed November 27, 2007].

[7]Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. Department of Health and Human Services. December 1, 2007; 1-143. Available at http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. Accessed December 12, 2007.