HIV CARE QUALITY TOOLKIT

HEDIS Measures for Rural and Community Practices

The Healthcare Effectiveness Data and Information Set (HEDIS) measures and National Committee for Quality Assurance (NCQA) guidelines are essential tools for improving quality of care for patients living with HIV. This toolkit is designed to provide clinicians, particularly those in rural and community-based practices, with a concise, point-of-care resource to align with these standards and enhance patient outcomes.

HEDIS is used by more than 90% of America's health plans to measure performance on important dimensions of care and service. HEDIS measures related to HIV care focus on promoting prevention, monitoring treatment adherence, and improving overall health outcomes. Below is a summary of the key measures:

To gain expert insight on how to integrate this into your clinical practice, see ***HIV and HEDIS: What Do Clinicians Need to Know***.

HIV Viral Load Suppression

Effective management of HIV is achieved when the viral load is suppressed to < 200 copies/mL. Achieving viral load suppression requires a systematic approach to patient management. Clinicians should emphasize the importance of antiretroviral therapy (ART) adherence during every visit and collaborate with patients to identify and address barriers, such as medication side effects, financial constraints, or lack of social support. Regular follow-up appointments should include a review of lab results, open-ended questions to assess adherence, and counseling to motivate patients toward achieving viral suppression.

BEST PRACTICES:

- Ensure routine viral load testing every 3-6 months
- Optimize adherence to ART

HIV Screening for Patients

The U.S. Centers for Disease Control and Prevention (CDC) recommends adults age 13–64 be screened for HIV at least once in their lifetime and annually for individuals at risk. *Clinicians can normalize HIV Testing by making HIV testing a routine part of care*.

HEDIS Measures for Rural and Community Practices

Incorporating HIV screening into standard workflows ensures broader coverage and early detection. To achieve this, clinics can create protocols for opt-out screening, where testing is presented as a routine part of care unless declined by the patient. Since specific state laws regarding opt-out HIV testing vary, clinicians should check individually each jurisdiction. To ensure you are helping patients in your area get the best care, remember to check your state's resources and **contact your local health department**.

Training staff to normalize discussions around HIV testing and addressing patient misconceptions can further improve uptake. Patients who may be at elevated risk should be identified through a thorough assessment of behavioral and demographic factors.

BEST PRACTICES:

- Normalize HIV Testing!

Access to Preventive Services

Pre-exposure prophylaxis (PrEP) is prescribed to people as an effective strategy to significantly reduce their chances of contracting the HIV virus. Preventive care involves proactive engagement with patients who may benefit from PrEP. Clinicians should incorporate risk assessments into routine visits and provide tailored education on PrEP's role in preventing HIV. Offering resources to address adherence challenges, such as reminders, pill organizers, or mobile apps can support patients in maintaining consistent use of PrEP.

BEST PRACTICES:

- Assess risk factors (e.g., sexual behavior, substance use)
- Educate patients about PrEP effectiveness and adherence

HEDIS Measures for Rural and Community Practices

Strategies to Improve HEDIS Scores in HIV Care are shown below:

1. **Maximize use of codes:** Submit accurate and timely claim/encounter data for every service
2. **Document comprehensively:** Include detailed medical history with dates and appropriate coding
3. **Focus on completed events:** Only completed events count toward HEDIS compliance
4. **Provide specific dates:** Ensure dates are specific enough to determine if a test or service was performed within the specified timeframe
5. **Educate schedulers:** Train staff to review for needed screenings, tests, and referrals
6. **Utilize automated testing, reminders, and recall tools in the electronic health record system:** Help patients schedule tests and follow up to ensure completion
7. **Educate patients:** Provide education on HIV management and rationale for tests
8. **Address barriers:** Ask open-ended questions to identify any barriers to care or treatment
9. **Collaborate with other providers:** Ensure comprehensive, safe, and effective care

HEDIS Measures for Rural and Community Practices

NCQA Guidelines for High-Quality HIV Care

The NCQA emphasizes comprehensive, patient-centered care, with a focus on integrating care coordination, chronic disease management, and social drivers of health. Clinicians can adopt a comprehensive care model by establishing a multidisciplinary team to address medical and non-medical needs. Care coordination involves maintaining clear communication with specialists, social workers, and other stakeholders. Regular team meetings can ensure alignment on patient care plans. Addressing social drivers of health may require leveraging local resources and community partnerships to connect patients with housing, food, or transportation assistance.

Patient engagement is another cornerstone of high-quality HIV care. Techniques such as motivational interviewing and shared decision-making help build trust and empower patients to take an active role in their treatment. Providing culturally sensitive care includes being aware of language preferences, religious beliefs, and stigma-related concerns that may impact adherence.

Point-of-Care Checklists

FOR INITIAL VISITS:

Initial visits are critical for establishing a baseline and building rapport with patients. During these visits, clinicians should ensure a thorough review of the patient's medical history, including prior ART use and comorbidities. Labs should be interpreted promptly, and treatment plans should be tailored to the patient's needs. Clinicians should also screen for mental health conditions and substance use, as these factors can significantly impact treatment adherence.

- Perform comprehensive medical history and physical exam
- Order baseline labs: CD4 count, HIV viral load, resistance testing
- Screen for co-infections: Hepatitis B/C, tuberculosis, STIs (e.g., syphilis)
- Assess mental health and substance use
- Initiate or adjust ART as indicated

HEDIS Measures for Rural and Community Practices

FOR FOLLOW-UP VISITS:

Follow-up visits are opportunities to track progress and address challenges. Regular lab monitoring helps evaluate the effectiveness of ART and detect potential side effects early. Clinicians should actively listen to patients' concerns about medication adherence and lifestyle changes, offering solutions such as support groups or adherence tools. Educational discussions should focus on empowering patients and their partners with prevention strategies.

- Review adherence to ART and address barriers
- Monitor labs (CD4 count, viral load, renal/hepatic function)
- Update immunizations as per CDC guidelines.
- Provide education on prevention strategies (e.g., PrEP for partners)
- Discuss quality-of-life concerns

BARRIERS FOR CONTINUUM OF CARE IN NONURBAN SETTINGS

- Shortage of health care providers and limited HIV expertise
- Scarcity of funding for widespread testing and treatment programs in non-urban areas
- Lack of systematic harm reduction programs and programs to address the root causes of HIV acquisition (e.g., opioid addiction, trauma, poverty)
- Increased geographic distance to providers and lack of transportation options
- Insufficient HIV awareness and knowledge at the community level
- High rates of poverty, low educational attainment, substandard housing and food insecurity
- Stigma, isolation, and heightened fear of discrimination
- Socially conservative climate, racism, anti-immigrant sentiment
- Limited community leadership and political support

HEDIS Measures for Rural and Community Practices

Implementation Tips for Rural Practices

OVERCOMING BARRIERS

1. Limited Specialist Access:
   - Use telehealth platforms to consult with infectious disease specialists

   Telehealth offers an effective solution for rural practices to connect with specialists. Setting up a reliable telehealth infrastructure and training staff to use these platforms can bridge gaps in care.

2. Stigma and Privacy Concerns:
   - Ensure confidentiality through secure communication systems
   - Conduct staff training on nonjudgmental, inclusive care

   To reduce stigma, clinics can adopt policies that prioritize patient privacy and confidentiality. Staff training programs should focus on creating a welcoming environment for all patients, regardless of their background or circumstances.

3. Resource Constraints
   - Partner with local health departments and AIDS Service Organizations (ASOs)
   - Apply for funding through Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program

   Resource limitations can be addressed by collaborating with community organizations and leveraging available funding opportunities. Practices should regularly review grant options to support service expansion and improve care delivery.

HEDIS Measures for Rural and Community Practices

Leveraging Technology

- Use electronic health records (EHRs) to track HEDIS measures
- Implement automated reminders for screenings and follow-ups

Technology can streamline workflows and enhance patient outcomes. EHRs with integrated reporting tools allow clinicians to monitor performance on HEDIS measures and identify areas for improvement. Automated reminders ensure timely follow-ups and routine screenings, improving patient adherence to care plans.

The effective implementation of HEDIS measures and adherence to NCQA guidelines can lead to improved quality of care for HIV patients in rural and community practices. By leveraging this toolkit, clinicians can enhance their practice, ensuring that patients receive comprehensive, high-quality care that meets national standards. It remains essential to continually refine these practices based on outcomes and evolving guidelines.

CHECKLIST FOR CLINICIANS AND TEAMS:

PATIENT-CENTERED SUPPORT & EDUCATION

✓ Comprehensive Patient Education:
- Use **motivational interviewing** to address adherence barriers
- Provide **culturally competent** counseling tailored to patient literacy levels

✓ Personalized Treatment Plans:
- Consider **once-daily regimens or long-acting injectable ART** to simplify adherence
- Address **comorbidities, mental health, and substance use** that may impact adherence

✓ Peer & Community Support Programs:
- Implement **peer navigation programs** and **HIV support groups**
- Engage community health workers to provide **ongoing adherence coaching**

CLINICAL WORKFLOWS & PROVIDER ENGAGEMENT

✓ Routine Adherence Assessment:
- Use validated tools like **self-reported adherence scales**, **pharmacy refill data**, and **pill counts**
- Incorporate adherence discussions into **every patient visit**

✓ Multidisciplinary Care Teams:
- Integrate **pharmacists, case managers, and mental health specialists** into HIV care teams
- Conduct **case reviews for patients at risk of non-adherence**

✓ Strengthen Provider-Patient Relationships:
- Promote **trust and stigma-free care** to enhance engagement
- Provide **telehealth or home visits** for patients with transportation barriers

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TECHNOLOGY & DIGITAL HEALTH TOOLS

✓ Electronic Health Record (EHR) Alerts & Data Integration:

- Use **clinical decision support** to flag patients with adherence challenges
- Track **viral load suppression rates** to meet quality measures

✓ Automated Medication Reminders & Digital Tools:

- **Text-based reminders, mobile apps (e.g., Medisafe), and AI-powered chatbots** help reinforce adherence
- **Smart pill bottles and electronic blister packs** provide real-time adherence data

✓ Pharmacy Collaboration & 90-Day Refills:

- Enroll patients in **automatic medication refills and mail-order pharmacy services**
- Implement **synchronization of refills** to reduce missed doses

ADDRESSING SOCIAL DRIVERS OF HEALTH

✓ Housing & Transportation Support:

- Provide **housing assistance programs** (e.g., Ryan White Part F Housing Assistance)
- Offer **transportation vouchers or ride-sharing options** for clinic visits

✓ Food Security & Employment Support:

- Connect patients to **food assistance programs**, as food insecurity is linked to **adherence challenges**
- Support **employment programs** that accommodate medical needs

✓ **Mental Health & Substance Use Interventions:**

- Expand **behavioral health services** and **integrate harm reduction approaches** for patients struggling with substance use

QUALITY MEASURE TRACKING & REPORTING

✓ Monitor Key Metrics:

- **Viral Load Suppression Rate (% of patients with HIV RNA < 200 copies/mL)**
- **ART Adherence Rate (% of patients with ≥ 90% adherence)**
- **Prescription Refill Adherence (% of patients with medication possession ratio ≥ 0.8)**

✓ Utilize Quality Improvement Programs:

- Participate in initiatives like **HRSA's HIV/AIDS Bureau quality improvement projects**
- Implement **Plan-Do-Study-Act (PDSA) cycles** to improve adherence interventions

PATIENT RESOURCES:

HIV.gov | **hiv.gov**

CDC HIV Resources for Patients | **cdc.gov/high-quality-care/hcp/resources/patient-resources.html**

CDC PrEP Information | **cdc.gov/hiv/prevention/prep.html**

Ready, Set, PrEP | **getyourprep.com**

HEDIS Measures for Rural and Community Practices

PATIENT RESOURCES *[CONT.]*:

AIDS info | **hivinfo.nih.gov**

Available Care and Services - Ryan White HIV/AIDS Program - HRSA | **ryanwhite.hrsa.gov/hiv-care/services**

AIDS Service Organizations (ASOs) | Use **hiv.gov** to find local ASOs

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