NATIONAL QUALITY FORUM

Measure Submission and Evaluation Worksheet 5.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the submitting standards web page.

NQF #: 0403   **NQF Project:** Infectious Disease Project
(for Endorsement Maintenance Review) **Original Endorsement Date:** Jul 31, 2008   **Most Recent Endorsement Date:** Jul 31, 2008 **Last Updated Date:** Aug 23, 2012

BRIEF MEASURE INFORMATION
De.1 Measure Title: HIV/AIDS: Medical Visit
Co.1.1 Measure Steward: National Committee for Quality Assurance
De.2 Brief Description of Measure: Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS, with at least two medical visits during the measurement year, with a minimum of 90 and 180 days between each visit
2a1.1 Numerator Statement: Numerator 1: Patients with at least two medical visits during the measurement year, with a minimum 0f 90 days between each visit Numerator 2: Patients with at least two medical visits during the measurement year, with a minimum of 180 days between each visit Definition of "Medical Visit" - any visit with a health care professional who provides routine primary care for the patient with HIV/AIDS (may be a primary care physician, ob/gyn, pediatrician or infectious diseases specialist)
2a1.4 Denominator Statement: All patients, regardless of age, with a diagnosis of HIV/AIDS
2a1.8 Denominator Exclusions: None.
1.1 Measure Type: Process **2a1. 25-26 Data Source:** Administrative claims, Electronic Clinical Data **2a1.33 Level of Analysis:** Clinician : Group/Practice, Clinician : Individual **1.2-1.4 Is this measure paired with another measure?** No **De.3 If included in a composite, please identify the composite measure** (*title and NQF number if endorsed*): N/A

STAFF NOTES (*issues or questions regarding any criteria*)
Comments on Conditions for Consideration:
Is the measure untested? Yes☐ No☐ If untested, explain how it meets criteria for consideration for time-limited endorsement:
1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (*check De.5*): 5. Similar/related endorsed or submitted measures (*check 5.1*): Other Criteria:
Staff Reviewer Name(s):

1. IMPACT, OPPORTUNITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See guidance on evidence.
Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)

1a. High Impact: H☐ M☐ L☐ I☐
(*The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.*)

De.4 Subject/Topic Areas (*Check all the areas that apply*): Infectious Diseases, Infectious Diseases : Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)
De.5 Cross Cutting Areas (*Check all the areas that apply*): Access

1a.1 Demonstrated High Impact Aspect of Healthcare: A leading cause of morbidity/mortality, Patient/societal consequences of poor quality, Severity of illness

1a.2 If "Other," please describe:

1a.3 Summary of Evidence of High Impact (*Provide epidemiologic or resource use data*):
Approximately 1.2 million people in the U.S. age 13 and older are estimated to be living with HIV and as many as 20 percent of them are undiagnosed. (CDC, 2012) Despite strong efforts that have prevented significant increases in new cases of HIV/AIDS since 2006, an average of 50,000 people are newly infected each year, (CDC, Aug 2011) and although the number of deaths due to HIV/AIDS infection declined 7 percent from 2006-2009, (CDC, Feb 2011) it is still one of the leading causes of death for black males and females and Hispanic/Latina females in the 35–44 age group. (CDC, 2012) These steady incidence rates and declining mortality rates mean more people than ever are living with HIV/AIDS; ensuring they receive recommended, high-quality care supports prevention efforts and significantly affects their ability to lead healthier lives. Preventing HIV and its related illness and death is a significant national health policy objective and 18 of the U.S. Healthy People 2020 goals are related to HIV prevention and treatment. (USDHHS, 2012)

Patients with HIV require lifelong medical care, but many do not receive it in an appropriate or timely manner. (Giordano, et al., 2007) Patients should have regular medical visits to routinely monitor disease progression. For example, clinical guidelines recommend monitoring HIV patient CD4 count at entry to care, every 3 to 6 months following antiretroviral therapy (ART), and every 6 to 12 months in stable patients with suppressed viral load. (OARAC, 2011) Additionally, the International Association of Physicians in AIDS Care (IAPAC) recommends systematic monitoring of retention in HIV care for all patients and notes that patients with HIV who are retained in care have been associated with improved health outcomes and a reduction in the spread of HIV within their communities (Thompson et al. 2012). The National HIV/AIDS strategy seeks to increase the percentage of Ryan White HIV/AIDS Program clients who receive "continuous care" (at least two visits for routine HIV medical care in 12 months) from 73 to 80 percent by 2015. (The White House, 2010)

There is a significant gap in the percentage of patients diagnosed with HIV/AIDS who are receiving routine medical care. A recent literature review found that anywhere from 45 to 55 percent of patients with known HIV do not receive any medical care over a 12-month period, and about 33 percent fail to receive care for up to 3 consecutive years. (Gardner, et al., 2011) Not receiving regular care prohibits patients from accessing antiretroviral therapy and prophylactic medications, leading to poor intermediate outcomes, like lack of viral load suppression, as well as higher mortality. (Mugavero, et al., 2012; Giordano, et al. 2007; Mugavero, et al. 2009) In addition, a recent analysis of the National HIV/AIDS Strategy effort to link patients with HIV to timely medical care was found to be cost-effective. (Gopalappa, et al., 2012)

1a.4 Citations for Evidence of High Impact cited in 1a.3: Centers for Disease Control and Prevention (CDC). HIV in the United States: At a Glance. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention Division of HIV/AIDS Prevention. Last Updated March 12, 2012. Accessed May 14, 2012. http://www.cdc.gov/hiv/resources/factsheets/us.htm

Centers for Disease Control and Prevention (CDC). Estimates of New HIV Infections in the United States, 2006–2009. CDC Fact Sheet, August 2011. Accessed May 14, 2012. http://www.cdc.gov/nchhstp/newsroom/HIVIncidenceResources.html

Centers for Disease Control and Prevention (CDC). HIV Surveillance Report, 2009; vol. 21. Published February 2011. Accessed May 14, 2012. http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/

Gardner EM, McLees MP, Steiner JF, et al. The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection. Clin Infect Dis. 2011 March 15; 52(6): 793–800.

Giordano TP, Gifford AL, White AC Jr, et al. Retention in care: a challenge to survival with HIV infection. Clin Infect Dis 2007; 44:1493–9.

Gopalappa C, Farnham PG, Hutchinson AB, Sansom SL. Cost-Effectiveness of the National HIV/AIDS Strategy (NHAS) Goal of Increasing Linkage to Care for HIV-Infected Persons. J Acquir Immune Defic Syndr. 2012 May 10. [Epub ahead of print]

Mugavero MJ, Amico KR, Westfall AO, Crane HM, Zinski A, Willig JH, Dombrowski JC, Norton WE, Raper JL, Kitahata MM, Saag MS. Early retention in HIV care and viral load suppression: implications for a test and treat approach to HIV prevention. J Acquir Immune Defic Syndr. 2012 Jan 1;59(1):86-93.

Mugavero MJ, Lin HY, Willig JH, et al. Missed visits and mortality among patients establishing initial outpatient HIV treatment. Clin Infect Dis 2009; 48:248–56.

Office of AIDS Research Advisory Council (OARAC) Working Group--HHS Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Morbidity and Mortality Weekly Report, vol. October 14, 2011.

USDHHS. Healthy People 2020 Topics and Objectives Index. Last updated May 1, 2012. http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx.

The White House Office of National AIDS Policy. National HIV/AIDS Strategy for the United States. July 2010.

Thompson, M.A., M.J. Mugavero, R.A. Amico, V.A. Cargill, L.W. Chang, R. Gross, C. Orrell, F.L. Altice, D.R. Bangsberg, J.G. Bartlett, C.G. Beckwith, N. Dowshen, C.M. Gordon, T. Horn, P. Kumar, J.D. Scott, M.J. Stirratt, R.H. Remien, J.M. Simoni, J.B. Nachega. 2012. "Guidelines for Improving Entry Into and Retention in Care and Antiretroviral Adherence for Persons With HIV: Evidence-Based Recommendations From an International Association of Physicians in AIDS Care Panel." Annals of Internal Medicine 156:817-833. http://annals.org/article.aspx?articleid=1170890

1b. Opportunity for Improvement: H☐ M☐ L☐ I☐
(*There is a demonstrated performance gap - variability or overall less than optimal performance*)

1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:
Guidelines from the HIV Medicine Association of the Infectious Disease Society of America state that patients who are engaged in care are more likely to remain adherent to their medication and have improved health outcomes. (HIVMA, 2009) Linking HIV patients to care and ensuring they receive regular treatment prevents their disease from progressing into AIDS and subsequent mortality, as well as the transmission of HIV to uninfected individuals. (Gardner, et al., 2011)

Aberg JA, Kaplan JE, Libman H, Emmanuel P, Anderson JR, Stone VE, Oleske JM, Currier JS, Gallant JE; HIV Medicine Association of the Infectious Diseases Society of America. Primary care guidelines for the management of persons infected with human immunodeficiency virus: 2009 update by the HIV medicine Association of the Infectious Diseases Society of America. Clin Infect Dis. 2009 Sep 1;49(5):651-81. Available at http://www.uphs.upenn.edu/bugdrug/antibiotic_manual/idsahivprimarycare2009.pdf. Accessed May 25, 2012.

Gardner EM, McLees MP, Steiner JF, et al. The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection. Clin Infect Dis. 2011 March 15; 52(6): 793–800.

1b.2 Summary of Data Demonstrating Performance Gap (*Variation or overall less than optimal performance across providers*):

[*For Maintenance – Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.*]
The National HIV/AIDS Strategy indicates that only 73% of patients with HIV/AIDS are receiving at least two medical visits a year (at least 60 days apart), which shows that there is room for improvement. (The White House, 2010)

Additional data will become available shortly, as the measure is included in the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and is also being considered for inclusion in CMS' Electronic Health Record (EHR) Incentive Program.

1b.3 Citations for Data on Performance Gap: [*For Maintenance – Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]
The White House Office of National AIDS Policy. National HIV/AIDS Strategy for the United States. July 2010.

1b.4 Summary of Data on Disparities by Population Group: [*For Maintenance –Descriptive statistics for performance results for this measure by population group*]
The measure is not stratified by patient groups or cohorts that could potentially be affected by disparities in care. NCQA has participated with IOM and others in attempting to include information on disparities in measure data collection. However, at the present time, this data is not coded in a standard manner and is incompletely captured. There are no consistent standards for what entity (physician, group, plan, and employer) should capture and report this data. While "requiring" reporting of the data could push the field forward, it has been our position that doing so would create substantial burden without generating meaningful results. We believe that the measure specifications should not require this unless absolutely necessary since the data needed to determine disparities cannot be ascertained from the currently available sources.

1b.5 Citations for Data on Disparities Cited in 1b.4: [*For Maintenance – Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]
N/A

1c. Evidence (*Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.*)
Is the measure focus a health outcome? Yes☐ No☐   **If not a health outcome**, rate the body of evidence.

Quantity: H☐ M☐ L☐ I☐   **Quality:** H☐ M☐ L☐ I☐   **Consistency:** H☐ M☐ L☐ I☐

Quantity	Quality	Consistency	Does the measure pass subcriterion1c?
M-H	M-H	M-H	Yes☐
L	M-H	M	Yes☐ IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise **No**☐
M-H	L	M-H	Yes☐ IF potential benefits to patients clearly outweigh potential harms: otherwise **No**☐
L-M-H	L-M-H	L	No ☐

Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service	Does the measure pass subcriterion1c? Yes☐ IF rationale supports relationship

1c.1 Structure-Process-Outcome Relationship (*Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome*):
This is a process measure.
Patient has visits (regular access to care) >> patient receives appropriate tests, screenings, and treatment >> patient is monitored appropriately >> patient's treatment regimen is managed and patient receives prophylaxis against opportunistic infections >> impact on morbidity and mortality

1c.2-3 Type of Evidence (*Check all that apply*):
Clinical Practice Guideline

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

1c.4 Directness of Evidence to the Specified Measure *(State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population)*:
The International Association of Physicians in AIDS Care (IAPAC) recommends systematic monitoring of retention in HIV care for all patients (II-A) and notes that patients with HIV who are retained in care have been associated with improved health outcomes and a reduction in the spread of HIV within their communities. The HIV Medicine Association recommends that asymptomatic HIV-infected patients with normal CD4 cell counts and low viral loads should be monitored with repeat HIV-RNA load measurements and CD4 cell counts every 3–4 months (B-II), and that all HIV-infected patients should be provided timely access to routine and urgent primary medical care (B-II). The New York State Department of Health AIDS Institute recommends that clinicians schedule routine monitoring visits at least every four months for all HIV-infected patients who are clinically stable (III).

Studies have shown that patients with HIV need lifelong medical care, but many do not remain in care. Moreover, low adherence to visits and poor engagement in care has been found to be a predictor of higher mortality. (Giordano, 2007)

1c.5 Quantity of Studies in the Body of Evidence *(Total number of studies, not articles)*: Three studies were cited in the IAPAC guideline. Two were retrospective cohort studies involving 3,162 patients. One study was an analysis of five existing measures of HIV care retention.

A total of ten studies were cited in the HIVMA guideline. Five were cohort studies including 19,320 patients. Two were case control studies covering 99 patients. One was cross-sectional study involving 707 patients.

The NYSDOH guideline cited one literature review study.

1c.6 Quality of Body of Evidence (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events)*: The IAPAC guideline concluded that the evidence was of high quality involving strong evidence from observational studies. The HIVMA guideline concluded that the evidence was of moderate quality with at least one clinical trial, cohort or case-controlled study. The NYSDOH guideline concluded that the evidence was based on expert opinion.

1c.7 Consistency of Results across Studies *(Summarize the consistency of the magnitude and direction of the effect)*: The studies consistently point towards the positive effect of regular medical visits on health outcomes such as lower mortality among patients with HIV/AIDS.

1c.8 Net Benefit *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms)*:
IAPAC: The IAPAC determined there was a positive net benefit for monitoring of HIV care retention for patients with HIV/AIDS.

HIVMA: The HIVMA determined there was a positive net benefit for regular medical visits for patients with HIV/AIDS.

NYSDOH: The NYSDOH determined there was a positive net benefit for regular medical visits for patients with HIV/AIDS.

1c.9 Grading of Strength/Quality of the Body of Evidence. Has the body of evidence been graded? Yes

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: IAPAC Guideline:
Development of these guidelines was funded by IAPAC through a grant from the National Institutes of Health Office of AIDS Research, but IAPAC did not have approval authority over specific recommendations or the completed manuscript. The IAPAC convened a panel of 31 members, consisting of experts in clinical care, clinical trials, behavioral science, pharmacy, and guideline methods and patient representatives. From this panel, 20 members volunteered to be on the writing team. Each member

completed a written conflict-of-interest disclosure. All potential conflicts of interest were declared, discussed, and resolved by the panel. The panel determined the issues to be covered on the basis of a systematic literature review and developed these guidelines using the Appraisal of Guidelines for Research and Evaluation (AGREE) II instrument for practice guideline assessment. This process was conducted in accordance with Institute of Medicine Standards for Developing Trustworthy Clinical Practice Guidelines.

HIVMA Guideline:
A panel of experts composed of specialists in internal medicine, pediatrics, infectious diseases, obstetrics, and gynecology prepared the 2009 update to these guidelines. All members of the panel participated in the preparation and review of the draft guidelines and feedback from external peer reviewers was obtained. These guidelines were reviewed and cleared by the CDC and the IDSA Standards and Practice Guidelines Committee. All members of the Expert Panel complied with the IDSA policy on conflicts of interest, which requires disclosure of any financial or other interest that might be construed as constituting an actual, potential, or apparent conflict. Members of the Expert Panel were provided with the IDSA's conflict of interest disclosure statement and asked to identify ties to companies developing products that might be affected by promulgation of the guidelines. Information was requested regarding employment, consultancies, stock ownership, honoraria, research funding, expert testimony, and membership on company advisory committees. The Panel made decisions on a case-by-case basis as to whether an individual's role should be limited as a result of a conflict. No limiting conflicts were identified.

NYSDOH Guideline:
The AIDS Institute's Office of the Medical Director directly oversees the development, publication, dissemination and implementation of clinical practice guidelines, in collaboration with The Johns Hopkins University, Division of Infectious Diseases. These guidelines are developed by distinguished committees of clinicians and others with extensive experience providing care to people with HIV infection. Committees meet regularly to assess current recommendations and to write and update guidelines in accordance with newly emerging clinical and research developments. All guidelines are externally peer reviewed by at least two experts in that particular area of patient care ensuring depth and quality of the guidelines. The HIV Consumer Advisory Committee (CAC) reviews all chapters.

1c.11 System Used for Grading the Body of Evidence: Other

1c.12 If other, identify and describe the grading scale with definitions: IAPAC Grading Scale:
Quality of the body of evidence: Excellent (I) - RCT evidence without important limitations or overwhelming evidence from observational studies; High (II) - RCT evidence with important limitations or strong evidence from observational
Studies; Medium (III) - RCT evidence with critical limitations or observational study evidence without important limitations; Low (IV) - Observational study evidence with important or critical limitations. Strength of recommendation:
Strong (A) - Almost all patients should receive the recommended course of action; Moderate (B) - Most patients should receive the recommended course of action. However, other choices may be appropriate for some patients. Optional (C) -There may be consideration for this recommendation on the basis of individual patient circumstances. Not recommended routinely.

HIVMA Grading Scale:
Strength of recommendation: Grade A - Good evidence to support a recommendation for use; Grade B - Moderate evidence to support a recommendation for use; Grade C - Poor evidence to support a recommendation. Quality of evidence: Level I - Evidence from at least 1 properly designed randomized, controlled trial; Level II - Evidence from at least 1 well-designed clinical trial, without randomization; from cohort or case-controlled analytic studies (preferably from 11 center); from multiple time series; or from dramatic results of uncontrolled experiments; Level III - Evidence from opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

NYSDOH Grading Scale:
Strength of Recommendation: A: Strong recommendation for the statement; B: Moderate recommendation for the statement; C: Optional recommendation. Quality of Evidence: I. One or more randomized trials with clinical outcomes and/or validated laboratory endpoints; II. One or more well-designed, non-randomized trials or observational cohort studies with long-term clinical outcomes; III. Expert opinion

1c.13 Grade Assigned to the Body of Evidence: A-II, B-II and III

1c.14 Summary of Controversy/Contradictory Evidence: The guidelines mentioned below recommend monitoring HIV patients every three to four months, but one study found that it may be reasonable for patients who have responded well to antiretroviral therapy (ART) and are on a well tolerated and durably fully suppressive ART regimen to have physician visits every six months. (Reekie, 2008)

1c.15 Citations for Evidence other than Guidelines *(Guidelines addressed below)*:
Giordano TP, Gifford AL, White AC Jr, et al. Retention in care: a challenge to survival with HIV infection. Clin Infect Dis 2007; 44:1493–9.

Reekie J, Mocroft A, Sambatakou H, et al. Does less frequent routine monitoring of patients on a stable, fully suppressed cART regimen lead to an increased risk of treatment failure? AIDS. 2008 Nov 12;22(17):2381-90.

1c.16 Quote verbatim, <u>the specific guideline recommendation</u> *(Including guideline # and/or page #)*:
[Strength of recommendation and quality of evidence are in parentheses, following each recommendation]

IAPAC Guideline (Thompson et al. 2012):
Systematic monitoring of retention in HIV care is recommended for all patients (II A).

HIVMA Guideline (Aberg, 2009):
Asymptomatic HIV-infected patients with normal CD4 cell counts and low viral loads should be monitored with repeat HIV-RNA load measurements and CD4 cell counts every 3–4 months (B-II). All HIV-infected patients should be provided timely access to routine and urgent primary medical care (B-II).

NYSDOH AIDS Institute Guideline (Office of the Medical Director, 2011):
Clinicians should schedule routine monitoring visits at least every four months for all HIV-infected patients who are clinically stable (III).

1c.17 Clinical Practice Guideline Citation: Aberg JA, Kaplan JE, Libman H, Emmanuel P, Anderson JR, Stone VE, Oleske JM, Currier JS, Gallant JE; HIV Medicine Association of the Infectious Diseases Society of America. Primary care guidelines for the management of persons infected with human immunodeficiency virus: 2009 update by the HIV medicine Association of the Infectious Diseases Society of America. Clin Infect Dis. 2009 Sep 1;49(5):651-81. Available at http://www.uphs.upenn.edu/bugdrug/antibiotic_manual/idsahivprimarycare2009.pdf. Accessed May 25, 2012.

Office of the Medical Director, New York State Department of Health AIDS Institute, Johns Hopkins University Division of Infectious Diseases. Primary Care Approach to the HIV-Infected Patient. April 2011. Available at: http://www.hivguidelines.org/clinical-guidelines/adults/primary-care-approach-to-the-hiv-infected-patient/. Accessed May 25, 2012.

Thompson, M.A., M.J. Mugavero, R.A. Amico, V.A. Cargill, L.W. Chang, R. Gross, C. Orrell, F.L. Altice, D.R. Bangsberg, J.G. Bartlett, C.G. Beckwith, N. Dowshen, C.M. Gordon, T. Horn, P. Kumar, J.D. Scott, M.J. Stirratt, R.H. Remien, J.M. Simoni, J.B. Nachega. 2012. "Guidelines for Improving Entry Into and Retention in Care and Antiretroviral Adherence for Persons With HIV: Evidence-Based Recommendations From an International Association of Physicians in AIDS Care Panel." Annals of Internal Medicine 156:817-833. http://annals.org/article.aspx?articleid=1170890

1c.18 National Guideline Clearinghouse or other URL: http://annals.org/article.aspx?articleid=1170890; http://www.hivguidelines.org/clinical-guidelines/adults/primary-care-approach-to-the-hiv-infected-patient/; (2) http://www.uphs.upenn.edu/bugdrug/antibiotic_manual/idsahivprimarycare2009.pdf

1c.19 Grading of Strength of Guideline Recommendation. Has the recommendation been graded? Yes

1c.20 If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: HIVMA, NYSDOH AIDS Institute, and IAPAC Guidelines

1c.21 System Used for Grading the Strength of Guideline Recommendation: Other

1c.22 If other, identify and describe the grading scale with definitions: IAPAC Grading Scale:
Quality of the body of evidence: Excellent (I) - RCT evidence without important limitations or overwhelming evidence from observational studies; High (II) - RCT evidence with important limitations or strong evidence from observational Studies; Medium (III) - RCT evidence with critical limitations or observational study evidence without important limitations; Low (IV) - Observational study evidence with important or critical limitations. Strength of recommendation:
Strong (A) - Almost all patients should receive the recommended course of action; Moderate (B) - Most patients should receive the recommended course of action. However, other choices may be appropriate for some patients. Optional (C) -There may be consideration for this recommendation on the basis of individual patient circumstances. Not recommended routinely.

HIVMA Grading Scale:
Strength of recommendation: Grade A - Good evidence to support a recommendation for use; Grade B - Moderate evidence to support a recommendation for use; Grade C - Poor evidence to support a recommendation. Quality of evidence: Level I - Evidence from at least 1 properly designed randomized, controlled trial; Level II - Evidence from at least 1 well-designed clinical trial, without randomization; from cohort or case-controlled analytic studies (preferably from 11 center); from multiple time series; or from dramatic results of uncontrolled experiments; Level III - Evidence from opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

NYSDOH AIDS Institute Grading Scale:
Strength of Recommendation: A: Strong recommendation for the statement; B: Moderate recommendation for the statement; C: Optional recommendation. Quality of Evidence: I. One or more randomized trials with clinical outcomes and/or validated laboratory endpoints; II. One or more well-designed, non-randomized trials or observational cohort studies with long-term clinical outcomes; III. Expert opinion

1c.23 Grade Assigned to the Recommendation: A-II, B-II and III

1c.24 Rationale for Using this Guideline Over Others: It is NCQA policy to use guidelines that are evidence-based, applicable to physicians and other healthcare providers, and developed by a national specialty organization or government agency.

NCQA and PCPI convened an expert panel of diverse stakeholders to review the guidelines and evidence for this measure. The panel determined the measure was scientifically sound using the full body of evidence and guidelines for this measure concept.

Based on the NQF descriptions for rating the evidence, what was the developer's assessment of the quantity, quality, and consistency of the body of evidence?
1c.25 Quantity: High   **1c.26** Quality: Moderate **1c.27** Consistency: High
1c.28 Attach evidence submission form:
1c.29 Attach appendix for supplemental materials:

Was the threshold criterion, *Importance to Measure and Report*, met?
(*1a & 1b must be rated moderate or high and 1c yes*) Yes ☐ No ☐
Provide rationale based on specific subcriteria:

For a new measure if the Committee votes NO, then STOP.
For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.

2. RELIABILITY & VALIDITY - SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)
Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See guidance on measure testing.

S.1 Measure Web Page *(In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained)*. Do you have a web page where current detailed specifications for this measure can be obtained? No

S.2 If yes, provide web page URL:

2a. RELIABILITY. Precise Specifications and Reliability Testing: H☐ M☐ L☐ I☐

2a1. Precise Measure Specifications. (*The measure specifications precise and unambiguous.*)

2a1.1 Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome)*:
Numerator 1: Patients with at least two medical visits during the measurement year, with a minimum 0f 90 days between each visit

Numerator 2: Patients with at least two medical visits during the measurement year, with a minimum of 180 days between each visit

Definition of "Medical Visit" - any visit with a health care professional who provides routine primary care for the patient with HIV/AIDS (may be a primary care physician, ob/gyn, pediatrician or infectious diseases specialist)

2a1.2 Numerator Time Window *(The time period in which the target process, condition, event, or outcome is eligible for inclusion)*:
12-month measurement period

2a1.3 Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, codes with descriptors, and/or specific data collection items/responses*:
Numerator 1: Patients with at least two medical visits during the measurement year, with a minimum of 90 days between each visit

Numerator 2: Patients with at least two medical visits during the measurement year, with a minimum of 180 days between each visit

Report CPT® E/M service code : 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245

2a1.4 Denominator Statement *(Brief, narrative description of the target population being measured)*:
All patients, regardless of age, with a diagnosis of HIV/AIDS

2a1.5 Target Population Category *(Check all the populations for which the measure is specified and tested if any)*: Adult/Elderly Care, Children's Health, Populations at Risk

2a1.6 Denominator Time Window *(The time period in which cases are eligible for inclusion)*:
12-month measurement period

2a1.7 Denominator Details (*All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:
All patients, regardless of age, with a diagnosis of HIV/AIDS

ICD-9 diagnosis codes: 042 or V08

Note: The denominators for the NCQA/AMA-PCPI HIV/AIDS measures have been harmonized, where appropriate.

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)*:
None.

2a1.9 Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:
N/A

2a1.10 Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses)*:
N/A

2a1.11 Risk Adjustment Type *(Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13)*: No risk adjustment or risk stratification   **2a1.12 If "Other," please describe:**

2a1.13 Statistical Risk Model and Variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.)*:
N/A

2a1.14-16 Detailed Risk Model Available at Web page URL (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL. Please supply login/password if needed:

2a1.17-18. Type of Score: Rate/proportion

2a1.19 Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*: Better quality = Higher score

2a1.20 Calculation Algorithm/Measure Logic *(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)*:
Measure Calculation
For performance purposes, this measure is calculated by creating a fraction with the following components: Denominator, Numerator, and Exceptions.

Step 1: Determine the eligible population. The eligible population is all the patients, regardless of age, with a diagnosis of HIV/AIDS.

Step 2: Determine number of patients meeting the denominator criteria as specified in Section 2a1.7 above.

Step 3: Determine the number of patients who meet the numerator criteria for each numerator as specified in section 2a1.3 above.

Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2 for each numerator.

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:
Attachment
PCPI_Sample_Calculation_Algorithm-634770920220307828.pdf

2a1.24 Sampling (Survey) Methodology. If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):
This measure is not based on a sample or survey.

2a1.25 Data Source *(Check all the sources for which the measure is specified and tested)*. If other, please describe:
 Administrative claims, Electronic Clinical Data

2a1.26 Data Source/Data Collection Instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*): N/A

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment:

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested*): Clinician : Group/Practice, Clinician : Individual

2a1.34-35 Care Setting (*Check all the settings for which the measure is specified and tested*): Ambulatory Care : Clinician Office/Clinic

2a2. Reliability Testing. (*Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability.*)

2a2.1 Data/Sample (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):
Measure Validity
The measure performance was calculated from data collected using two different methods of collection:
-Automated electronic health record report
-Visual inspection of the medical record by professional data abstractors to capture the data elements to manually construct the performance

The data source was electronic health records in the ambulatory care setting. The data sample came from four sites representing community health centers serving primarily low-income and uninsured patients with multiple, complex needs in the Midwest region. The sample consisted of 1,580 patient encounters. Visual inspection of the medical records was performed in 2009.

2a2.2 Analytic Method (*Describe method of reliability testing & rationale*):
As referenced in the NQF Guidance on Measure Testing (2011), separate reliability testing of the data elements is not required if empirical validity testing of the data elements is conducted (e.g., if the validity of ICD-9 codes in administrative claims data as compared to clinical diagnoses in the medical record is demonstrated, then inter-coder or inter-abstractor reliability would not be required). Consequently, we are submitting validity testing results to demonstrate reliability for this measure.

Measure Validity
Data from a performance report for the measure automatically-generated from the electronic health record (designed to collect the necessary data elements to identify eligible cases and calculate the performance score) were compared to data elements found and scores calculated manually on visual inspection of the medical record by trained abstractors.

Data analysis included percent agreement at the denominator and numerator.

2a2.3 Testing Results (*Reliability statistics, assessment of adequacy in the context of norms for the test conducted*):
Measure Validity
Below are the results when comparing electronic health record automated report to visual inspection of the medical record.
Automated calculation of performance=90.8%
Manual calculation of performance=95%
Percentage Point Difference between Automated and Manual=4%

2b. VALIDITY. Validity, Testing, including all Threats to Validity: H☐ M☐ L☐ I☐

2b1.1 Describe how the measure specifications (*measure focus, target population, and exclusions*) **are consistent with the**

evidence cited in support of the measure focus (*criterion 1c*) and identify any differences from the evidence:
The evidence is consistent with the focus and scope of this measure.

2b2. Validity Testing. (*Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.*)

2b2.1 Data/Sample (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):
Measure Validity
The measure performance was calculated from data collected using two different methods of collection:
-Automated electronic health record report
-Visual inspection of the medical record by professional data abstractors to capture the data elements to manually construct the performance

The data source was electronic health records in the ambulatory care setting. The data sample came from four sites representing community health centers serving primarily low-income and uninsured patients with multiple, complex needs in the Midwest region. The sample consisted of 1,580 patient encounters. Visual inspection of the medical records was performed in 2009.

Face Validity
An expert panel was used to assess the face validity of this measure when it was re-evaluated in 2012. The full list of panel members is provided under the section Additional Information, Ad.1. Workgroup/Expert Panel Involved in Measure Development – 2012 (Measure Review) Panel.

2b2.2 Analytic Method (*Describe method of validity testing and rationale; if face validity, describe systematic assessment*):
Measure Validity
Data from a performance report for the measure automatically-generated from the electronic health record (designed to collect the necessary data elements to identify eligible cases and calculate the performance score) were compared to data elements found and scores calculated manually on visual inspection of the medical record by trained abstractors.

Data analysis included percent agreement at the denominator and numerator.

Face Validity
Face validity of the measure score as an indicator of quality was systematically assessed as follows. After the measure was fully specified, the expert panel was asked to rate their agreement with the following statement:
The scores obtained from the measure as specified will provide an accurate reflection of quality and can be used to distinguish good and poor quality. Scale 1-5, where 1=Strongly Disagree; 3=Neither Agree or Disagree; 5=Strongly Agree.

2b2.3 Testing Results (*Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment*):
Measure Validity
Below are the results when comparing electronic health record automated report to visual inspection of the medical record.
Automated calculation of performance=90.8%
Manual calculation of performance=95%
Percentage Point Difference between Automated and Manual=4%

Face Validity
The results of the expert panel rating of the validity statement were as follows: N=6; Mean rating=4.67 and 100% of respondents either agree or strongly agree that this measure can accurately distinguish good and poor quality.

The results of the expert panel rating of the validity statement were as follows:
Frequency/Distribution of Ratings
1 (Strongly Disagree)-0 members
2-0 members
3 (Neither Agree or Disagree)-0 members

4-2 members
5 (Strongly Agree)-4 members

POTENTIAL THREATS TO VALIDITY. (<u>*All*</u> *potential threats to validity were appropriately tested with adequate results.*)

2b3. Measure Exclusions. (*Exclusions were supported by the clinical evidence in 1c or appropriately tested with results demonstrating the need to specify them.*)

2b3.1 Data/Sample for analysis of exclusions *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
N/A

2b3.2 Analytic Method *(Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference)*:
N/A

2b3.3 Results *(Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):*
N/A

2b4. Risk Adjustment Strategy. (*For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.*)

2b4.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
N/A

2b4.2 Analytic Method (*Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables)*:
N/A

2b4.3 Testing Results (<u>*Statistical risk model*</u>: *Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models.* <u>*Risk stratification*</u>: *Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata)*:
N/A

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment: N/A

2b5. Identification of Meaningful Differences in Performance. (*The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.*)

2b5.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
The National HIV/AIDS Strategy indicates that only 73% of patients with HIV/AIDS are receiving at least two medical visits a year (at least 60 days apart), which shows that there is room for improvement. (The White House, 2010)

Additional data will become available shortly, as the measure is included in the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and is also being considered for inclusion in CMS' Electronic Health Record (EHR) Incentive Program. NCQA will share this data as it becomes available.

2b5.2 Analytic Method *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance)*:
N/A

2b5.3 Results *(Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of*

statistically significant and meaningfully differences in performance):
N/A

2b6. Comparability of Multiple Data Sources/Methods. (*If specified for more than one data source, the various approaches result in comparable scores.*)

2b6.1 **Data/Sample** *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
This measure has not been compared across data sources.

2b6.2 **Analytic Method** *(Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure)*:
N/A

2b6.3 **Testing Results** *(Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted)*:
N/A

2c. Disparities in Care: H☐ M☐ L☐ I ☐ NA☐ (*If applicable, the measure specifications allow identification of disparities.*)

2c.1 **If measure is stratified for disparities, provide stratified results** *(Scores by stratified categories/cohorts)*: The measure is not stratified by patient groups or cohorts that could potentially be affected by disparities in care. NCQA has participated with IOM and others in attempting to include information on disparities in measure data collection. However, at the present time, this data is not coded in a standard manner and is incompletely captured. There are no consistent standards for what entity (physician, group, plan, and employer) should capture and report this data. While "requiring" reporting of the data could push the field forward, it has been our position that doing so would create substantial burden without generating meaningful results. We believe that the measure specifications should not require this unless absolutely necessary since the data needed to determine disparities cannot be ascertained from the currently available sources.

2c.2 **If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:**
N/A

2.1-2.3 **Supplemental Testing Methodology Information:**

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met?
(*Reliability and Validity must be rated moderate or high*) Yes☐ No☐
Provide rationale based on specific subcriteria:

If the Committee votes No, STOP

3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (**evaluation criteria**)

C.1 **Intended Actual/Planned Use** *(Check all the planned uses for which the measure is intended)*: Public Reporting, Quality Improvement (Internal to the specific organization)

3.1 **Current Use** *(Check all that apply; for any that are checked, provide the specific program information in the following questions)*: Public Reporting, Quality Improvement (Internal to the specific organization)

3a. Usefulness for Public Reporting: H☐ M☐ L☐ I ☐

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

(*The measure is meaningful, understandable and useful for public reporting.*)

3a.1. **Use in Public Reporting - disclosure of performance results to the public at large** *(If used in a public reporting program, provide name of program(s), locations, Web page URL(s)).* If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: [*For Maintenance – If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.*]

This measure is included in the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and is being considered for inclusion in CMS' Electronic Health Record (EHR) Incentive Program. Results are not yet available, as the Medicaid Core Set was established in early 2012 and CMS' EHR Incentive Program has not yet begun collecting data. These national and state initiatives will provide excellent venues for reporting performance publicly.

3a.2. **Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting.** If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results: The inclusion of this measure in the Initial Core Set of Health Care Quality Measures supports the feasibility and usability of the measure specification on a state scale, and the inclusion of a similar measure in the HIVQUAL program supports the meaningfulness and usefulness of the measure on a national scale.

3.2 **Use for other Accountability Functions (payment, certification, accreditation).** If used in a public accountability program, provide name of program(s), locations, Web page URL(s): This measure is being considered for inclusion in CMS' Electronic Health Record (EHR) Incentive Program. This measure may be used in a Maintenance of Certification program.

3b. **Usefulness for Quality Improvement: H☐ M☐ L☐ I ☐**
(*The measure is meaningful, understandable and useful for quality improvement.*)

3b.1. **Use in QI.** If used in quality improvement program, provide name of program(s), locations, Web page URL(s):
[*For Maintenance – If not used for QI, indicate the reasons and describe progress toward using performance results for improvement*].
The Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB) uses a similar measure in its Core Clinical Performance Measure Module (PMM). This module is a reporting tool that allows providers to compare their performance regionally and nationally to other providers, and supports quality improvement.

3b.2. **Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement.** If usefulness was demonstrated *(e.g., QI initiative),* describe the data, method and results:
The measure aligns with current clinical practice guidelines and the National HIV/AIDS Strategy. Also, a similar retention in care measure is used by HAB's PMM, indicating that a measure with this focus is meaningful for quality improvement for this patient population.

Overall, to what extent was the criterion, *Usability*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

---

4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (**evaluation criteria**)

4a. **Data Generated as a Byproduct of Care Processes: H☐ M☐ L☐ I ☐**

4a.1-2 **How are the data elements needed to compute measure scores generated?** *(Check all that apply).*
Data used in the measure are:
generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable
Created on: 08/24/2012 at 12:14 PM

15

4b. Electronic Sources: H ☐ M ☐ L ☐ I ☐

4b.1 Are the data elements needed for the measure as specified available electronically *(Elements that are needed to compute measure scores are in defined, computer-readable fields)*: ALL data elements are in a combination of electronic sources

4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources:

4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences: H ☐ M ☐ L ☐ I ☐

4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:
We are not aware of any unintended consequences related to this measurement.

4d. Data Collection Strategy/Implementation: H ☐ M ☐ L ☐ I ☐

A.2 Please check if either of the following apply (*regarding proprietary measures*): Proprietary measure
4d.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues *(e.g., fees for use of proprietary measures)*:
As a result of our current review of the measures and our experience with the measures since 2008, we have learned and subsequently changed the NCQA/AMA-PCPI HIV/AIDS measures in the following ways.
•   We have attempted to limit the number of exclusions/exceptions in these measures due to difficulties accurately capturing them in the health record.
•   We have combined measures that address similar clinical areas (e.g., STD screening) into one measure to support feasibility and implementation.

Overall, to what extent was the criterion, *Feasibility*, met? H ☐ M ☐ L ☐ I ☐
Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes ☐ No ☐
Rationale:

If the Committee votes No, STOP.
If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

5. COMPARISON TO RELATED AND COMPETING MEASURES

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure before a final recommendation is made.

5.1 If there are related measures *(either same measure focus or target population)* or competing measures *(both the same measure focus and same target population)*, list the NQF # and title of all related and/or competing measures:

5a. Harmonization

5a.1 If this measure has EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):
Are the measure specifications completely harmonized?

5a.2 If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden:

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

5b. Competing Measure(s)

5b.1 If this measure has both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures *(e.g., a more valid or efficient way to measure quality);* OR provide a rationale for the additive value of endorsing an additional measure. *(Provide analyses when possible)*:

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia, 20005

Co.2 Point of Contact: Bob, Rehm, Assistant Vice President, Performance Measurement, Rehm@ncqa.org, 202-955-1728-

Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance, 1100 13th Street NW, Washington, District Of Columbia, 20005

Co.4 Point of Contact: Dawn, Alayon, MPH, CPH, alayon@ncqa.org, 202-955-3533-

Co.5 Submitter: Dawn, Alayon, MPH, CPH, Senior Health Care Analyst, alayon@ncqa.org, 202-955-3533-, National Committee for Quality Assurance

Co.6 Additional organizations that sponsored/participated in measure development:
Physician Performance Measures (Measures) and related data specifications have been developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement™ (the Consortium) and the National Committee for Quality Assurance (NCQA). The Health Resources and Services Administration (HRSA) and the Infectious Diseases Society of America also participated in the development of this measure.

Co.7 Public Contact: Bob, Rehm, Assistant Vice President, Performance Measurement, Rehm@ncqa.org, 202-955-1728-, National Committee for Quality Assurance

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development
Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.
2007-2008 (Measure Development) Panel
The measure development panel helped guide development of this measure. Staff sought member feedback on all components of the measure (including denominator, numerator, exclusions). The panel met multiple times to achieve consensus on the measures and to address questions about the measure.

Workgroup members
Judith Aberg- Bellevue Hospital Center- New York University (co-chair)
Michael Horberg- Santa Clara Medical Center (co-chair)
Bruce Agins- New York State Department of Health AIDS Institute (NYSDOH)
Steven Asch- RAND Health Communications
Larry Bryant-Housingworks- Advocacy & Organizing
Sophia Chang- California Healthcare Foundation
Laura Cheever- Health Resources and Services Administration (HRSA)
Antoine Douaihy- UPMC Mercy
Arry Deiudonne- Center for Children- University Hospital
Patricia Emmanuel- University of South Florida
Marcy Fenton- LA County Department of Public Health
Joel Gallant- Johns Hopkins University School of Medicine

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

Joseph Gathe- Texas Medical Center
Cyril Goshima- Hawaii AIDS Education and Training Center
Andrew Hamilton- Alliance of Chicago
Lisa Hischhorn- Harvard Medical School, JSI Research and Training Institute
Jan King- Los Angeles County Department of Health Services
W. Christopher Matthews- UC San Diego, Department of Medicine
James L. Raper- University of Alabama at Birmingham
Jennifer Read- National Institutes of Health (NIH)
Kimberly Smith- Rush University Medical Center
Alice Stek- University of Southern California
Valerie Stone- Harvard Medical School, Massachusetts General Hospital
Bob Tracy- Bob Tracy Consulting
Paul Voldberding- VAMC
Rochelle Walensky- Massachusetts General Hospital
Bruce Williams- University of New Mexico Health Sciences Center

Liaisons
Brigid Krezek- American College of Obstetricians and Gynecologists
Dan Green- Centers for Medicare & Medicaid Services (CDC)
Deborah Willis-Fillinger- Health Resources and Services Administration (HRSA)
Magda Barini-Garcia- Health Resources and Services Administration (HRSA)
Lori DeLorenzo- Health Resources and Services Administration (HRSA)
Christine Lubinski- Infectious Diseases Society of America/ HIV Medicine Association
Jennifer Padberg- Infectious Diseases Society of America/ HIV Medicine Association

2012 (Measure Review) Panel
The measure review panel reviewed the existing measure against current clinical practice guidelines to ensure it reflected current evidence.

Workgroup members
Judith Aberg- New York University School of Medicine
Bruce Agins- New York State Department of Health AIDS Institute (NYSDOH)
Allison Agwu- Johns Hopkins Medical Institutions
Marc Foca- Columbia University
Rohan Hazra- National Institutes of Health (NIH)
Lisa Hirschhorn- Harvard Medical School, JSI Research and Training Institute
Gregory Lucas- Johns Hopkins University
Michael Horberg- Mid-Atlantic Permanente Group, PC
Vicki Peters- NYC Department of Health and Mental Hygiene
Alice Stek- University of Southern California School of Medicine
Bruce Williams- University of New Mexico Health Sciences Center

Liaisons
Laura Cheever- Health Resources and Services Administration (HRSA)
Anna Huang- Health Resources and Services Administration (HRSA)
Marlene Matosky- Health Resources and Services Administration (HRSA)
John Brooks- Centers for Disease Control and Prevention (CDC)
Abigail Viall- Centers for Disease Control and Prevention (CDC)
Pascale Wortley- Centers for Disease Control and Prevention (CDC)

Ad.2 If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward: N/A

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable
Created on: 08/24/2012 at 12:14 PM

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.3 **Year the measure was first released:** 2008
Ad.4 **Month and Year of most recent revision:** 06, 2012
Ad.5 **What is your frequency for review/update of this measure?** Every three years, or sooner if clinical guidelines are updated
Ad.6 **When is the next scheduled review/update for this measure?**

Ad.7 **Copyright statement:** This Measure, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposed, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, (on behalf of the Consortium) or NCQA. Neither the AMA, NCQA, Consortium nor its members shall be responsible for any use of the Measure.

© 2012 American Medical Association and National Committee for Quality Assurance. All Rights Reserved

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

Ad.8 **Disclaimers:** These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Ad.9 **Additional Information/Comments:** There are no related or competing measures endorsed by NQF. The U.S. Health Resources & Services Administration (HRSA) plans to submit several HIV measures during the Infectious Diseases Call for Measures that are similar in concept to this measure. This measure has been reviewed by a panel of experts and aligns with current guidelines and the National HIV/AIDS Strategy. HRSA participated in our expert panel meeting, and we have engaged HRSA in several other conversations to attempt to harmonize our measures.

Date of Submission (*MM/DD/YY*): 07/02/2012

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable
Created on: 08/24/2012 at 12:14 PM

19

Sample PCPI Calculation Algorithm

Calculation for Performance
For performance purposes, a measure is calculated by creating a fraction with the following components: Numerator, Denominator, and Denominator Exclusions.

Numerator (A) Includes:
Number of patients meeting numerator criteria
Denominator (PD) Includes:
Number of patients meeting criteria for denominator inclusion

Denominator Exclusions (C) Include:
Number of patients with valid medical, patient or system exclusions (where applicable; will differ by measure)

Performance Calculation

$$\frac{A\ (\#\ of\ patients\ meeting\ numerator\ criteria)}{PD\ (\#\ patients\ in\ denominator) - C\ (\#\ patients\ with\ valid\ denominator\ exclusions)}$$

If a measure does not allow for exclusion(s), it is calculated by creating a fraction with the following components: Numerator and Denominator.

Numerator (A) Includes:
Number of patients meeting numerator criteria
Denominator (PD) Includes:
Number of patients meeting criteria for denominator inclusion

$$\frac{A\ (\#\ of\ patients\ meeting\ measure\ criteria)}{PD\ (\#\ of\ patients\ in\ denominator)}$$

It is also possible to calculate the percentage of patients excluded overall, or excluded by medical, patient, or system reason where applicable:

Overall Exclusion Calculation

$$\frac{C\ (\#\ of\ patients\ with\ any\ valid\ exclusion)}{PD\ (\#\ patients\ in\ denominator)}$$

OR

Exclusion Calculation by Type

$$\frac{C_1\ (\#\ patients\ with\ medical\ reason)}{PD\ (\#\ patients\ in\ denominator)} \qquad \frac{C_2\ (\#\ patients\ with\ patient\ reason)}{PD\ (\#\ patients\ in\ denominator)} \qquad \frac{C_3\ (\#\ patients\ with\ system\ reason)}{PD\ (\#\ patients\ in\ denominator)}$$