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 #: 0408 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: Sep 06, 2012

BRIEF MEASURE INFORMATION

De.1 Measure Title: HIV/AIDS: Tuberculosis (TB) Screening

Co.1.1 Measure Steward: National Committee for Quality Assurance

De.2 Brief Description of Measure: Percentage of patients aged 3 months and older with a diagnosis of HIV/AIDS, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection.

2a1.1 Numerator Statement: Patients for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection.

NOTE: Results from the tuberculin skin test must be interpreted by a healthcare professional.

2a1.4 Denominator Statement: All patients aged 3 months and older with a diagnosis of HIV/AIDS, who had at least two visits during the measurement year, with at least 90 days in between each visit

2a1.8 Denominator Exclusions: Documentation of Medical Reason for not performing a tuberculosis (TB) screening test (e.g., patients with a history of positive PPD or treatment for TB)

1.1 Measure Type: Process
2a1. 25-26 Data Source: Electronic Clinical Data : Electronic Health Record
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, OPPORTUITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable
Created on: 09/21/2012 at 10:44 AM

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), Infectious Diseases : Screening, Infectious Diseases : Tuberculosis
De.5 Cross Cutting Areas (*Check all the areas that apply)*:

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 top 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)

People infected with HIV/AIDS are at increased risk of latent or active tuberculosis (TB) infection, and about 30% of people with HIV who have latent TB will eventually get active TB. (Akolo, Shepperd, & Volmink, 2010) People with TB compared to those without are more likely to have diagnosed HIV infection (about 12% in 2006), while the percentage of TB cases with undiagnosed HIV status has increased to 32%. (CDC, 2009) HIV patients with TB have an increased risk of severe lung disease and death, making screening for the disease an important preventive measure for these patients. (Gray, Young, & Cotton, 2009) Also, supporting the need for TB screening is that unlike other AIDS-related opportunistic infections, CD4 count is not a reliable predictor of increased risk for TB disease in HIV-infected persons. (CDC, 2009)

1a.4 Citations for Evidence of High Impact cited in 1a.3: Akolo C, Adetifa I, Shepperd S, Volmink J. Treatment of latent tuberculosis infection in HIV infected persons. Cochrane HIV/AIDS Group. Published Online: 20 JAN 2010 DOI: 10.1002/14651858.CD000171.pub3

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/

Centers for Disease Control and Prevention (CDC), the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. Morbidity and Mortality Weekly Report, vol. 58, April 10, 2009.

Gray DM, Young T, Cotton M, Zar H. The impact of tuberculosis preventive therapy on tuberculosis and death in HIV-infected children. Cochrane HIV/AIDS Group. Published Online: 7 OCT 2009 DOI: 10.1002/14651858.CD006418.pub2

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

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:
HIV-infected adults, adolescents, and children with TB have an increased risk of severe lung disease and death. Identifying and treating TB is important to decreasing morbidity and mortality among patients with HIV.

Gray DM, Young T, Cotton M, Zar H. The impact of tuberculosis preventive therapy on tuberculosis and death in HIV-infected children. Cochrane HIV/AIDS Group. Published Online: 7 OCT 2009 DOI: 10.1002/14651858.CD006418.pub2

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.*]
Although this measure is not yet publicly reported, there is a similar measure in the HIVQUAL-US program, a program designed to improve care for people living with HIV/AIDS through quality improvement, performance measurement, and infrastructure/capacity building. It is funded through a cooperative agreement administered by the Health Resources & Services Administration's HIV/AIDS Bureau. Ryan White HIV/AIDS Part C and Part D Programs are eligible to participate. Inclusion of a similar measure in this program indicates that this is an important measurement topic for the HIV population.

Data from HIVQUAL indicate there is a gap in care with room for improvement. The HIVQUAL measure assesses the percentage of patients without prior positive test or TB treatment who received a TB test with documented result during the past 24 months. The following data from 2009 is based on a random sample of 9,755 patients from 204 facilities. The facility mean rate was 68.7%.

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*]
JSI. HIVQUAL-US Performance Data Report. Ryan White Part C and Part D Funded Programs. October 2011. pp: 1-20.

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.
Screening patients with HIV for TB >> Identify infection >> Treat TB >> Reduce development of severe lung disease >> Reduce morbidity and mortality

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

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)*:
Clinical practice guidelines released by the Centers for Disease Control and Prevention (CDC) recommend that all persons should be tested for latent tuberculosis infection (LTBI) at the time of HIV diagnosis regardless of their TB risk category (A-II). The HIV Medicine Association (HIVMA) guidelines recommend that upon initiation of care, HIV-infected patients should be tested for Mycobacterium tuberculosis infection by either a TST applied on the volar surface of the forearm by the Mantoux (intradermal injection) method with an intermediate-strength purified protein derivative (0.1 mL containing 5 TU) or by an interferon-g release assay (A-I). Pediatric guidelines from the CDC also recommend annual testing of children with HIV infection to diagnose LTBI (A-III).

1c.5 Quantity of Studies in the Body of Evidence *(Total number of studies, not articles)*: The CDC guidelines on the prevention and treatment of opportunistic infections in HIV-infected adults/adolescents cited seven studies. Two of them were cohort studies of 223 patients. Three were cross-sectional studies including 340 patients. Two were literature reviews covering 143 individual studies.

CDC Prevention and Treatment of Opportunistic Infections in HIV-Exposed and –Infected Children Guidelines cited five studies. Two of the studies were case-control studies involving 474 children, and three were cohort studies including 2005 children.

The HIVMA guideline cited the National Institute of Health guideline titled “Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents” and the CDC recommendation titled “Anergy Skin Testing and Preventive Therapy for HIV-Infected Persons: Revised Recommendations”. The NIH guideline included six studies, of which two were randomized trials of 1303 patients; two were cohort studies of 866 patients; and two were cross-sectional studies of 302 patients. The CDC recommendation included 49 studies, of which at least one was randomized controlled trial 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 quality of the body of evidence is high with at least one clinical trial, cohort or case-controlled study and at least one properly-designed randomized controlled trial study.

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 having a tuberculosis (TB) screening test at least once since the diagnosis of HIV infection on health outcomes, including prevention and treatment of TB 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)*:
CDC Prevention and Treatment of Opportunistic Infections in HIV-infected Adults and Adolescents Guidelines: The panel determined there was a positive net benefit for prevention of opportunistic infections in HIV-infected adults and adolescents.

CDC Prevention and Treatment of Opportunistic Infections in HIV-Exposed and –Infected Children Guidelines: The panel determined there was a positive net benefit for prevention of opportunistic infections in HIV-exposed and infected children.

HIVMA Guidelines: The HIVMA determined there was a positive net benefit for prevention of opportunistic infections in patients with HIV.

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: CDC Adult/Adolescents Guidelines:
These guidelines were developed by a panel of specialists from the United States government and academic institutions. For each infection covered in the guidelines, a small group of specialists with content-matter expertise reviewed the literature for new information since the guidelines were last pub¬lished; they then proposed revised recommendations at a meeting held at NIH in June 2007. After those presentations and a discussion, the revised guidelines were further reviewed by the co-editors; by the Office of AIDS Research, NIH; by specialists at CDC; and by HIVMA of IDSA before final approval and publication. CDC and its planners and content specialists disclosed they had no finan¬cial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters, with the exception of Constance Benson and King K. Holmes. Dr. Benson disclosed being on the Advisory Board for Merck, GlaxoSmithKline, and Boehringer Ingelheim; being a grant recipient for Gilead; and being a Data Safety Monitoring Board (DSMB) member for Achillion and JJR Australia. Her spouse also was a consultant for Merck, Gilead, Achillion, Monogram, and Vertex. Dr. Holmes disclosed being a DSMB member of Merck, receiving an honorarium at the 2005 Infectious Diseases Society of America Conference, and serving on the Mycology Research Laboratories scientific advisory board. However, their presentations did not include any discussion of the unlabeled use of a product or a product under investigational use.

CDC Pediatrics Guidelines:
The guidelines were developed by a panel of specialists in pediatric HIV infection and infectious diseases (the Pediatric Opportunistic Infections Working Group) from the U.S. government and academic institutions. For each OI, a pediatric specialist with content-matter expertise reviewed the literature for new information since the last guidelines were published; they then proposed revised recommendations at a meeting at the National Institutes of Health (NIH) in June 2007. After these presentations and discussions, the guidelines underwent further revision, with review and approval by the Working Group, and final endorsement by NIH, CDC, the HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America (IDSA), the Pediatric Infectious Disease Society (PIDS), and the American Academy of Pediatrics (AAP). CDC and its planners and content specialists disclosed they had no financial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters, with the exception of Kenneth Dominguez, who serves on Advisory Board for Committee on Pediatric AIDS (COPD) –Academy of Pediatrics and Kendel International, Inc. antiretroviral Pregnancy Registry and Peter Havens serves on the Advisory board for Abbott Laboratories, Grant Co. Investigator for Gilead, Merck, and Bristrol-Myers Squibb as well as a Grant Recipient for BI, GlaxoSmithKline, Pfizer, Tibotec and Orthobiotech.

HIVMA Guidelines:
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.

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

1c.12 If other, identify and describe the grading scale with definitions: CDC Guidelines:
Rating Strength of recommendation: A: Both strong evidence for efficacy and substantial clinical benefit support recommendation for use. Should always be offered; B: Moderate evidence for efficacy—or strong evidence for efficacy but only limited clinical benefit—supports recommendation for use. Should generally be offered; C: Evidence for efficacy is insufficient to support a recommendation for or against use. Or evidence for efficacy might not outweigh adverse conse¬quences (e.g. drug toxicity, drug interactions) or cost of the treatment or alternative approaches. Optional; D: Moderate evidence for lack of efficacy or for adverse outcome supports a recommendation against use. Should generally not be offered; E: Good evidence for lack of efficacy or for adverse outcome supports a recommendation against use. Should never be offered. Rating Quality of the evidence supporting the recommendation: I: Evidence from at least one properly-designed randomized, controlled trial; II: Evidence from at least one well-designed clinical trial without randomization, from cohort or case-controlled analytic studies (preferably from more than one center), or from multiple time-series studies, or dramatic results from uncontrolled experiments; III: Evidence from opinions of respected authorities based on clinical experience, descriptive studies, or reports of expert committees.

HIVMA Guidelines:
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.

1c.13 Grade Assigned to the Body of Evidence: A-I to A-III

1c.14 Summary of Controversy/Contradictory Evidence: CDC guidelines for the prevention of opportunistic infections in adults and adolescents with HIV recommend annual testing for latent TB infection "for HIV-infected persons who are or remain in a "high-risk" category for repeated or ongoing exposure to persons with active TB (i.e., persons who are or who have been incarcerated, live in congregate settings, are active drug users, or have other sociodemographic risk factors for TB (A-III)." CDC guidelines for the prevention of opportunistic infections in children with HIV also recommend annual testing (A-III). Evidence ratings for populations needing annual TB screening are based on expert opinion, and despite a strong strength of recommendation, NCQA believes TB screening since diagnosis of HIV is a more appropriate measure for the total HIV population.

1c.15 Citations for Evidence other than Guidelines*(Guidelines addressed below)*:
N/A

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

HIVMA Guidelines (Aberg, 2009):
Upon initiation of care, HIV-infected patients should be tested for Mycobacterium tuberculosis infection by either a TST applied on the volar surface of the forearm by the Mantoux (intradermal injection) method with an intermediate-strength purified protein derivative (0.1 mL containing 5 TU) or by an interferon-g release assay (A-I). Those with positive test results should be treated for latent M. tuberculosis infection after acute tuberculosis has been excluded. Repeat testing is recommended in patients with advanced HIV disease who initially had negative TST results but subsequently experienced an increase in the CD4 cell count to 1200 cells/mm3 while receiving antiretroviral therapy and who, thus, may have restored sufficient immunocompetence to mount a

positive reaction (A-III). HIV-infected patients who are close contacts of persons with infectious tuberculosis should be treated for latent M. tuberculosis infection regardless of their TST results, age, or prior courses of tuberculosis treatment after the diagnosis of active tuberculosis has been excluded (A-II).

CDC Adult and Adolescent Guidelines (CDC, April 2009):
All persons should be tested for LTBI at the time of HIV diagnosis regardless of their TB risk category (A-II). Persons with negative diagnostic tests for LTBI, advanced HIV infec¬tion (CD4+ count <200 cells/μL), and without indications for initiating empiric LTBI treatment should be re-tested for LTBI once they start ART and attain a CD4+ count >200 cells/μL (A-III). In general, annual testing for LTBI is recommended for HIV-infected persons who are or remain in a "high-risk" category for repeated or ongoing exposure to persons with active TB, i.e., persons who are or who have been incarcerated, live in congregate settings, are active drug users, or have other sociodemographic risk factors for TB (A-III). All HIV-infected persons with a positive diagnostic test for LTBI should undergo chest radiography and clinical evaluation to rule out active TB (A-I).

CDC Pediatric Guidelines (CDC, Sept. 2009):
The cornerstone of diagnostic methods for latent TB infection (LTBI) is the tuberculin skin test (TST), administered by the Mantoux method. Because children with HIV infection are at high risk for TB, annual testing of this population is recommended to diagnose LTBI (A-III).

Recently, ex vivo assays that determine interferon-g release from lymphocytes after stimulation by highly specific synthetic M. tuberculosis antigens have been developed to diagnose infection. QuantiFERON®-TB Gold and QuantiFERON-TB Gold In-Tube (Cellestis Limited, Valencia, California) and the T-SPOT®.TB assay (Oxford Immunotec, Marlborough, Massachusetts) are now Food and Drug Administration (FDA)-approved and available in the United States. These tests were more specific than the TST in studies among adults, especially among those who are BCG vaccinated. However, as with the TST, these tests are less sensitive in HIV-infected adults with advanced immune suppression. In addition, limited data suggest these tests, particularly QuantiFERON, might have less sensitivity for diagnosing infection in young children. Their routine use for finding LTBI or diagnosing TB in HIV-infected children is not recommended because of uncertainty about test sensitivity (D-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.

Centers for Disease Control and Prevention (CDC), NIH, and the IDSA. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. Morbidity and Mortality Weekly Report, vol. 58, April 10, 2009. Available at: http://www.aidsinfo.nih.gov/contentfiles/Adult_OI.pdf. Accessed May 25, 2012.

Centers for Disease Control and Prevention (CDC), NIH, IDSA, Pediatric Infectious Diseases Society, American Academy of Pediatrics. Guidelines for the Prevention and Treatment of Opportunistic Infections Among HIV-Exposed and HIV-Infected Children. Morbidity and Mortality Weekly Report, vol. 58, September 4, 2009. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e0826a1.htm. Accessed May 25, 2012.

1c.18 National Guideline Clearinghouse or other URL:
http://www.uphs.upenn.edu/bugdrug/antibiotic_manual/idsahivprimarycare2009.pdf;
http://www.aidsinfo.nih.gov/contentfiles/Adult_OI.pdf;http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e0826a1.htm

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 Guidelines;expert consensus with evidence review/ CDC Adult/Adolescent Guidelines; expert consensus with evidence review/ CDC Pediatric Guidelines; expert consensus with evidence review

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

1c.22 If other, identify and describe the grading scale with definitions: 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.

CDC Grading Scale:
Rating strength of recommendation- A: Both Strong evidence for efficacy and substantial clinical benefit support recommendation for use. Should always be offered. B: Moderate evidence for efficacy- or strong evidence for efficacy but only limited clinical benefit-supports recommendation for use. Should generally be offered. C: evidence for efficacy is insufficient to support a recommendation for or against use. Or evidence for efficacy might not outweigh adverse consequences (e.g drug toxicity, drug interactions) or cost of the treatment of alternative approaches. Optional. D: Moderate evidence for lack of efficacy or for adverse outcome supports a recommendation against use. Should generally not be offered. E: Good evidence for lack of efficacy or for adverse outcome supports a recommendation against use. Should never be offered. Rating Quality of the evidence supporting the recommendation: I: Evidence from at least one properly-designed randomized, controlled trial. II: Evidence from at least one well-designed clinical trial without randomization, from cohort or case-controlled analytic studies (preferably from more than on center), or from multiple time-series studies, or dramatic results from uncontrolled experiments. III: Evidence from opinions of respected authorities based on clinical experience, descriptive studies, or reports of expert committees.

1c.23 Grade Assigned to the Recommendation: A-I to A-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: High1c.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? Yes

S.2 If yes, provide web page URL: The NQF endorsed measure is available on AMA´s website: http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI

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)*:
Patients for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection.

NOTE: Results from the tuberculin skin test must be interpreted by a healthcare professional.

2a1.2 Numerator Time Window *(The time period in which the target process, condition, event, or outcome is eligible for inclusion)*:
Since diagnosis of HIV infection

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*:

2a1.4 Denominator Statement *(Brief, narrative description of the target population being measured)*:
All patients aged 3 months and older with a diagnosis of HIV/AIDS, who had at least two visits during the measurement year, with at least 90 days in between each visit

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)*:
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)

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)*:
Documentation of Medical Reason for not performing a tuberculosis (TB) screening test (e.g., patients with a history of positive PPD or treatment for TB)

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)*:

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, Exclusions.

Step 1: Determine the eligible population. The eligible population is all patients, aged 3 months and older, 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 as specified in Section 2a1.3. The numerator includes all patients in the denominator population who had a TB screening test performed.

Step 4: Test for patients with valid exclusions from Step 3.

Step 5: Calculate the rate by dividing the total from Step 4 by the total from Step 2.

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:
Attachment
PCPI_Sample_Calculation_Algorithm-634768432553834044.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:
Electronic Clinical Data : Electronic Health Record

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 1,506 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, numerator, and exclusion.

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=36.6%
Manual calculation of performance=56%
Percentage Point Difference between Automated and Manual=20%

The difference between scores resulted from the lack of standardized fields for “results interpretation,” “history of positive PPD,” or “treatment for TB” in the electronic health record at the test sites. This data, however, was available from the paper medical record.

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 1,506 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, numerator, and exclusions.

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=36.6%
Manual calculation of performance=56%
Percentage Point Difference between Automated and Manual=20%

The difference between scores resulted from the lack of standardized fields for “results interpretation,” “history of positive PPD,” or “treatment for TB” in the electronic health record at the test sites. This data, however, was available from the paper medical record.

Face Validity
The results of the expert panel rating of the validity statement were as follows: N=8; Mean rating=3.63 and 62.5% 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
2-3 members
3 (Neither Agree or Disagree)-0 members
4-2 members
5 (Strongly Agree)-3 members

Face validity results reflected a few workgroup members believed that a TB screening should be performed annually. Evidence ratings for populations needing annual TB screening are based on expert opinion, and despite a strong strength of recommendation (A-III), NCQA believes that TB screening since diagnosis of HIV is a more appropriate measure for the total HIV population.

POTENTIAL THREATS TO VALIDITY. (*All 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)*:
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 24 patient encounters. Visual inspection of the medical records was performed in 2009.

2b3.2 Analytic Method (*Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference)*:
-An automated report of performance was created.
-Manual abstractors reviewed each patient who did not meet the measure according to the automated report.
-Exceptions were documented even for performance measures that did not allow for exceptions in the specifications in an attempt to see whether some measures should include denominator exceptions to more accurately reflect quality.

2b3.3 Results *(Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):*
The automated report was unable to capture exceptions for this measure, as there was no discrete field in the electronic health record for allowable exceptions. The percentage of false negatives due to exception (the number of patients who appeared to fail the measure on automated calculation but were found to not meet the numerator and have a valid exception on the manual review) was 25% for this measure. Most of the exceptions were due to history of positive PPD.

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 *(Statistical risk model: 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. Risk stratification: 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)*:
Although this measure is not yet publicly reported, there is a similar measure in the HIVQUAL-US program, a program designed to improve care for people living with HIV/AIDS through quality improvement, performance measurement, and infrastructure/capacity building. It is funded through a cooperative agreement administered by the Health Resources & Services Administration's HIV/AIDS Bureau. Ryan White HIV/AIDS Part C and Part D Programs are eligible to participate. Inclusion of a similar measure in this program indicates that this is an important measurement topic for the HIV population.

Data from HIVQUAL indicate there is a gap in care with room for improvement. The HIVQUAL measure assesses the percentage of patients without prior positive test or TB treatment who received a TB test with documented result during the past 24 months. The following data from 2009 is based on a random sample of 9,755 patients from 204 facilities.

2b5.2 Analytic Method *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance)*:
HIVQUAL-US
HIVQUAL-US provides a facility mean.

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)*:
HIVQUAL-US
The facility mean rate was 68.7%.

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 ☐
(*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.*]
While this measure is not currently used in national public reporting initiatives, NCQA will submit the NQF-endorsed measure to PQRS for consideration.

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: A similar TB screening measure is used by HIVQUAL-US, indicating that a measure with this focus is meaningful and useful for public reporting programs.

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 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. Also, the measure specifications are made freely available on the PCPI website and through the implementation efforts of medical specialty societies.

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:
A similar TB screening 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)

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:

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
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

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.

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: N/A

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

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

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

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

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

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

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

OR

Exclusion Calculation by Type

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

Text Description for eSpecification

Measure Title	HIV/AIDS: Tuberculosis (TB) Screening
Measure #	0408
Measure Description	Percentage of patients aged 3 months and older with a diagnosis of HIV/AIDS, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection
Measurement Period	Twelve consecutive months
Initial Patient Population	All patients aged 3 months and older with a diagnosis of HIV/AIDS, who had at least two visits during the measurement year, with at least 90 days in between each visit
Denominator Statement	Equals Initial Patient Population
Numerator Statement	Patients for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection
Denominator Exclusions	Documentation of Medical Reason for not performing a tuberculosis (TB) screening test (e.g., patients with a history of positive PPD or treatment for TB)

Data Elements for eSpecification

QDM Standard Category*	QDM Data Type*	Standard Terminology	Constraints	Value Set Name	Data Source	Comments/Rationale
Initial Patient Population						
Individual Characteristic	Patient Characteristic	LN	starts before the start of measurement period	Date of Birth	Electronic Health Record (EHR)	
Individual Characteristic	Patient Characteristic	Calculated	starts before start of measurement period	Age	Electronic Health Record (EHR)	Measurement start date minus Date of Birth must be greater than or equal to 3 months.
Condition/Diagnosis/Problem	Diagnosis, Active	SNOMED-CT, ICD-9-CM, ICD-10-CM	starts before or during measurement period	HIV	Electronic Health Record (EHR)	
Encounter	Encounter, Performed	CPT, SNOMED-CT	occurs during measurement period	HIV Visit	Electronic Health Record (EHR)	HIV Visit value set consists of following value sets: Office Visit; Outpatient Consultation; Preventive Care - Initial Office Visit, 0 to 17; Preventive Care Services-Initial Office Visit, 18 and Up; Preventive Care - Established Office Visit, 0 to 17; Preventive Care Services - Established Office Visit, 18 and Up; and Face-to-Face Interaction.
Numerator						
Laboratory Test	Laboratory Test, Result	LOINC	starts after start of HIV diagnosis	Tuberculosis (TB) Screening	Electronic Health Record (EHR)	Result must be present in EHR.

QDM Standard Category	QDM Data Type	Standard Terminology	Constraints	Value Set Name	Data Source	Comments/Rationale
Procedure	Procedure, Result	SNOMED-CT	starts after start of HIV diagnosis	Finding of Tuberculin Skin Test	Electronic Health Record	Result must be present in EHR.
Exception						
Laboratory Test	Laboratory Test, Not Done	SNOMED-CT	starts after start of HIV diagnosis	Medical Reason	Electronic Health Record (EHR)	Patients who had a Medical Reason for not getting a TB screening are excepted from the measure.
Supplemental Data Elements						
Individual Characteristic	Patient Characteristic	Administrative Sex	occurs during measurement period	ONC Administrative Sex	Electronic Health Record (EHR)	The Supplemental Data Elements (SDE) are collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	CDC	occurs during measurement period	Race	Electronic Health Record (EHR)	The Supplemental Data Elements (SDE) are collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	CDC	occurs during measurement period	Ethnicity	Electronic Health Record (EHR)	The Supplemental Data Elements (SDE) are collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	Source of Payment Typology	occurs during measurement period	Payer	Electronic Health Record (EHR)	The Supplemental Data Elements (SDE) are collected for the purpose of stratifying results in an effort to highlight disparities.

*The Quality Data Model (QDM), version 2.1, was developed by the National Quality Forum (NQF)

eSpecification
HIV/AIDS: Tuberculosis (TB) Screening

Value Set OID	Measure Component	Standard Concept	Standard Category	Taxonomy	Code	Code Descriptor
2.16.840.1.113883.3.560.100.4	IPP	Date of Birth	Individual Characteristic	LOINC	21112-8	Birth date
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	5810003	Human immunodeficiency virus (HIV) infection with infection by another virus (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	40780007	Human immunodeficiency virus I infection (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	48794007	Human immunodeficiency virus (HIV) infection with infectious mononucleosis-like syndrome (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	52079000	Congenital human immunodeficiency virus infection (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	62246005	Acquired immunodeficiency syndrome (AIDS)-like syndrome (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	62479008	Acquired immune deficiency syndrome (AIDS) (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	77070006	Acquired immunodeficiency syndrome (AIDS) with Salmonella infection (disorder)

Value Set OID	Measure Component	Standard Concept	Standard Category	Taxonomy	Code	Code Descriptor
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	79019005	Human immunodeficiency virus II infection (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	86406008	Human immunodeficiency virus infection (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	87117006	Human immunodeficiency virus (HIV) infection with acute lymphadenitis (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	91947003	Asymptomatic human immunodeficiency virus infection (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	111880001	Acute HIV infection (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	186706006	Human immunodeficiency virus infection constitutional disease (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	186707002	Human immunodeficiency virus infection with neurological disease (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	186708007	Human immunodeficiency virus infection with secondary clinical infectious disease (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	186709004	Human immunodeficiency

Value Set OID	Measure Component	Standard Concept	Standard Category	Taxonomy	Code	Code Descriptor
						virus with secondary cancers (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	186717007	Human immunodeficiency virus (HIV) disease resulting in mycobacterial infection (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	186718002	Human immunodeficiency virus (HIV) disease resulting in cytomegaloviral disease (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	186719005	Human immunodeficiency virus (HIV) disease resulting in candidiasis (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	186721000	Human immunodeficiency virus (HIV) disease resulting in multiple infections (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	186723002	Human immunodeficiency virus (HIV) disease resulting in Burkitt's lymphoma (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	186725009	Human immunodeficiency virus (HIV) disease resulting in multiple malignant neoplasms (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	186726005	Human immunodeficiency virus (HIV) disease

Value Set OID	Measure Component	Standard Concept	Standard Category	Taxonomy	Code	Code Descriptor
						resulting in lymphoid interstitial pneumonitis (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	230180003	Human immunodefiency virus leukoencephalopathy (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	230201009	Human immunodeficiency virus myelitis (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	230598008	Neuropathy due to human immunodeficiency virus (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	235009000	Human immunodeficiency virus-associated periodontitis (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	235726002	Human immunodeficiency virus enteropathy (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	240103002	Human immunodeficiency virus myopathy (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	276666007	Congenital human immunodeficiency virus positive status syndrome (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	315019000	Human immunodeficiency virus (HIV) infection with aseptic meningitis (disorder)

Value Set OID	Measure Component	Standard Concept	Standard Category	Taxonomy	Code	Code Descriptor
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	359791000	Acquired immunodeficiency syndrome (AIDS) with dermatomycosis (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	397763006	Human immunodefiency virus encephalopathy (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	398329009	Human immunodefiency virus encephalitis (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	402915006	Human immunodeficiency virus (HIV) seroconversion exanthem (disorder)
2.16.840.1.113883.3.464.1003.120.11.1005	IPP	HIV	Condition/Diagnosis/Problem	SNOMED-CT	402916007	Human immunodeficiency virus (HIV) seropositivity (disorder)
2.16.840.1.113883.3.464.1003.120.11.1006	IPP	HIV	Condition/Diagnosis/Problem	ICD-9-CM	042	Human immunodeficiency virus [HIV] disease
2.16.840.1.113883.3.464.1003.120.11.1006	IPP	HIV	Condition/Diagnosis/Problem	ICD-9-CM	V08	Asymptomatic human immunodeficiency virus [HIV] infection status
2.16.840.1.113883.3.464.1003.120.11.1007	IPP	HIV	Condition/Diagnosis/Problem	ICD-10-CM	B20	Human immunodeficiency virus [HIV] disease
2.16.840.1.113883.3.464.1003.120.11.1007	IPP	HIV	Condition/Diagnosis/Problem	ICD-10-CM	Z21	Asymptomatic human immunodeficiency virus [HIV] infection status
2.16.840.1.113883.3.464.1003.101.11.1005	IPP	Office Visit	Encounter	CPT	99201	NA
2.16.840.1.113883.3.464.1003.101.11.1005	IPP	Office Visit	Encounter	CPT	99202	NA

Value Set OID	Measure Component	Standard Concept	Standard Category	Taxonomy	Code	Code Descriptor
2.16.840.1.113883.3.464.1003.101.11.1005	IPP	Office Visit	Encounter	CPT	99203	NA
2.16.840.1.113883.3.464.1003.101.11.1005	IPP	Office Visit	Encounter	CPT	99204	NA
2.16.840.1.113883.3.464.1003.101.11.1005	IPP	Office Visit	Encounter	CPT	99205	NA
2.16.840.1.113883.3.464.1003.101.11.1005	IPP	Office Visit	Encounter	CPT	99212	NA
2.16.840.1.113883.3.464.1003.101.11.1005	IPP	Office Visit	Encounter	CPT	99213	NA
2.16.840.1.113883.3.464.1003.101.11.1005	IPP	Office Visit	Encounter	CPT	99214	NA
2.16.840.1.113883.3.464.1003.101.11.1005	IPP	Office Visit	Encounter	CPT	99215	NA
2.16.840.1.113883.3.464.1003.101.11.1040	IPP	Outpatient Consultation	Encounter	CPT	99241	NA
2.16.840.1.113883.3.464.1003.101.11.1040	IPP	Outpatient Consultation	Encounter	CPT	99242	NA
2.16.840.1.113883.3.464.1003.101.11.1040	IPP	Outpatient Consultation	Encounter	CPT	99243	NA
2.16.840.1.113883.3.464.1003.101.11.1040	IPP	Outpatient Consultation	Encounter	CPT	99244	NA
2.16.840.1.113883.3.464.1003.101.11.1040	IPP	Outpatient Consultation	Encounter	CPT	99245	NA
2.16.840.1.113883.3.464.1003.101.11.1110	IPP	Preventive Care - Initial Office Visit, 0 to 17	Encounter	CPT	99381	NA
2.16.840.1.113883.3.464.1003.101.11.1110	IPP	Preventive Care - Initial Office Visit, 0 to 17	Encounter	CPT	99382	NA
2.16.840.1.113883.3.464.1003.101.11.1110	IPP	Preventive Care - Initial Office Visit, 0 to 17	Encounter	CPT	99383	NA
2.16.840.1.113883.3.464.1003.101.11.1110	IPP	Preventive Care - Initial Office Visit, 0 to 17	Encounter	CPT	99384	NA
2.16.840.1.113883.3.464.1003.101.11.1115	IPP	Preventive Care Services-Initial Office Visit, 18 and	Encounter	CPT	99385	NA

Value Set OID	Measure Component	Standard Concept	Standard Category	Taxonomy	Code	Code Descriptor
		Up				
2.16.840.1.113883.3.464.1003.101.11.1115	IPP	Preventive Care Services-Initial Office Visit, 18 and Up	Encounter	CPT	99386	NA
2.16.840.1.113883.3.464.1003.101.11.1115	IPP	Preventive Care Services-Initial Office Visit, 18 and Up	Encounter	CPT	99387	NA
2.16.840.1.113883.3.464.1003.101.11.1120	IPP	Preventive Care - Established Office Visit, 0 to 17	Encounter	CPT	99391	NA
2.16.840.1.113883.3.464.1003.101.11.1120	IPP	Preventive Care - Established Office Visit, 0 to 17	Encounter	CPT	99392	NA
2.16.840.1.113883.3.464.1003.101.11.1120	IPP	Preventive Care - Established Office Visit, 0 to 17	Encounter	CPT	99393	NA
2.16.840.1.113883.3.464.1003.101.11.1120	IPP	Preventive Care - Established Office Visit, 0 to 17	Encounter	CPT	99394	NA
2.16.840.1.113883.3.464.1003.101.11.1125	IPP	Preventive Care Services - Established Office Visit, 18 and Up	Encounter	CPT	99395	NA

Value Set OID	Measure Component	Standard Concept	Standard Category	Taxonomy	Code	Code Descriptor
2.16.840.1.113883.3.464.1003.101.11.1125	IPP	Preventive Care Services - Established Office Visit, 18 and Up	Encounter	CPT	99396	NA
2.16.840.1.113883.3.464.1003.101.11.1125	IPP	Preventive Care Services - Established Office Visit, 18 and Up	Encounter	CPT	99397	NA
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	4525004	emergency department patient visit (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	12843005	subsequent hospital visit by physician (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	18170008	subsequent nursing facility visit (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	19681004	nursing evaluation of patient and report (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	87790002	follow-up inpatient consultation visit (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	90526000	initial evaluation and management of healthy individual (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	185349003	encounter for "check-up" (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	185463005	visit out of hours (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	185465003	weekend visit (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	207195004	history and physical examination with evaluation and management of

Value Set OID	Measure Component	Standard Concept	Standard Category	Taxonomy	Code	Code Descriptor
						nursing facility patient (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	270427003	patient-initiated encounter (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	270430005	provider-initiated encounter (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	308335008	patient encounter procedure (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	390906007	follow-up encounter (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	406547006	urgent follow-up (procedure)
2.16.840.1.113883.3.464.1003.101.11.1216	IPP	Face-to-Face Interaction	Encounter	SNOMED-CT	439708006	home visit (procedure)
2.16.840.1.113883.3.464.1003.107.11.1025	N	Tuberculosis Screening	Laboratory Test	LOINC	45323-3	Mycobacterium tuberculosis tuberculin stimulated gamma interferon [Presence] in Blood
2.16.840.1.113883.3.464.1003.107.11.1025	N	Tuberculosis Screening	Laboratory Test	LOINC	39263-9	Tuberculin screen test status CPHS
2.16.840.1.113883.3.464.1003.107.11.1025	N	Tuberculosis Screening	Laboratory Test	LOINC	71773-6	Mycobacterium tuberculosis stimulated gamma interferon [Presence] in Blood
2.16.840.1.113883.3.464.1003.107.11.1025	N	Tuberculosis Screening	Laboratory Test	LOINC	39208-4	Tuberculosis exposure screen assessment Set CPHS
2.16.840.1.113883.3.464.1003.107.11.1025	N	Tuberculosis Screening	Laboratory Test	LOINC	39211-8	Tuberculosis exposure screen finding recency CPHS
2.16.840.1.113883.3.464.1003.107.11.1025	N	Tuberculosis Screening	Laboratory Test	LOINC	39210-0	Tuberculosis exposure screen follow-up status CPHS

Value Set OID	Measure Component	Standard Concept	Standard Category	Taxonomy	Code	Code Descriptor
2.16.840.1.113883.3.464.1003.107.11.1025	N	Tuberculosis Screening	Laboratory Test	LOINC	39209-2	Tuberculosis exposure screen results indicator CPHS
2.16.840.1.113883.3.464.1003.107.11.1025	N	Tuberculosis Screening	Laboratory Test	LOINC	45688-9	Tuberculosis Minimum Data Set
2.16.840.1.113883.3.464.1003.107.11.1025	N	Tuberculosis Screening	Laboratory Test	LOINC	54792-7	Tuberculosis in last 7 days MDSv3
2.16.840.1.113883.3.464.1003.116.11.1035	N	Finding of Tuberculin Skin Test	Procedure	SNOMED-CT	164980000	Mantoux: delayed reaction (finding)
2.16.840.1.113883.3.464.1003.116.11.1035	N	Finding of Tuberculin Skin Test	Procedure	SNOMED-CT	268375009	Mantoux: negative (finding)
2.16.840.1.113883.3.464.1003.116.11.1035	N	Finding of Tuberculin Skin Test	Procedure	SNOMED-CT	268376005	Mantoux: positive (finding)
2.16.840.1.113883.3.464.1003.116.11.1035	N	Finding of Tuberculin Skin Test	Procedure	SNOMED-CT	441846005	Nonspecific tuberculin test reaction (finding)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	31438003	drug resistance (disorder)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	35688006	complication of medical care (disorder)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	59037007	drug intolerance (disorder)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	62014003	adverse reaction to drug (disorder)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	79899007	drug interaction (finding)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	161590003	history of - drug allergy (situation)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	183932001	procedure contraindicated (situation)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	183964008	treatment not indicated (situation)
2.16.840.1.113883.3.526.2.313	Exc	Medical	Laboratory Test	SNOMED-CT	183966005	drug treatment not

Value Set OID	Measure Component	Standard Concept	Standard Category	Taxonomy	Code	Code Descriptor
		Reason				indicated (situation)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	216952002	failure in dosage (event)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	266721009	absent response to treatment (situation)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	269191009	late effect of medical and surgical care complication (disorder)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	274512008	drug therapy discontinued (situation)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	371133007	treatment modification (procedure)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	397745006	medical contraindication (finding)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	407563006	treatment not tolerated (situation)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	410534003	not indicated (qualifier value)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	410536001	contraindicated (qualifier value)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	416098002	drug allergy (disorder)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	416406003	procedure discontinued (situation)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	428119001	procedure not indicated (situation)
2.16.840.1.113883.3.526.2.313	Exc	Medical Reason	Laboratory Test	SNOMED-CT	445528004	treatment changed (situation)

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eSpecification
HIV/AIDS: Tuberculosis (TB) Screening
Supplemental Data Elements (SDE) Value Sets

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
National Library of Medicine	2.16.840.1.113762.1.4.1	ONC Administrative Sex	Individual Characteristic	Administrative Sex	HL7 v2.5	F	Female
National Library of Medicine	2.16.840.1.113762.1.4.1	ONC Administrative Sex	Individual Characteristic	Administrative Sex	HL7 v2.5	M	Male
National Library of Medicine	2.16.840.1.113762.1.4.1	ONC Administrative Sex	Individual Characteristic	Administrative Sex	HL7 v2.5	U	Unknown
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	1002-5	American Indian or Alaska Native
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2028-9	Asian
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2054-5	Black or African American
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2076-8	Native Hawaiian or Other Pacific Islander
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2106-3	White
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2131-1	Other Race
CDC NCHS	2.16.840.1.114222.4.11.837	Ethnicity	Individual Characteristic	CDC	1.0	2135-2	Hispanic or Latino
CDC NCHS	2.16.840.1.114222.4.11.837	Ethnicity	Individual Characteristic	CDC	1.0	2186-5	Not Hispanic or Latino
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	1	MEDICARE

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	2	MEDICAID
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3	OTHER GOVERNMENT (Federal/State/Local) (excluding Department of Corrections)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	4	DEPARTMENTS OF CORRECTIONS
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	5	PRIVATE HEALTH INSURANCE
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	6	BLUE CROSS/BLUE SHIELD
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	7	MANAGED CARE, UNSPECIFIED(to be used only if one can't distinguish public from private)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	8	NO PAYMENT from an Organization/Agency/Program/Private Payer Listed
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	9	MISCELLANEOUS/OTHER
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	11	Medicare (Managed Care)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	12	Medicare (Non-managed Care)

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	19	Medicare Other
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	21	Medicaid (Managed Care)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	22	Medicaid (Non-managed Care Plan)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	23	Medicaid/SCHIP
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	24	Medicaid Applicant
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	25	Medicaid - Out of State
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	29	Medicaid Other
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	31	Department of Defense
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	32	Department of Veterans Affairs
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	33	Indian Health Service or Tribe

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	34	HRSA Program
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	35	Black Lung
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	36	State Government
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	37	Local Government
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	38	Other Government (Federal, State, Local not specified)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	39	Other Federal
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	41	Corrections Federal
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	42	Corrections State
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	43	Corrections Local
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	44	Corrections Unknown Level

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	51	Managed Care (Private)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	52	Private Health Insurance - Indemnity
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	53	Managed Care (private) or private health insurance (indemnity), not otherwise specified
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	54	Organized Delivery System
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	55	Small Employer Purchasing Group
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	59	Other Private Insurance
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	61	BC Managed Care
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	62	BC Indemnity
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	63	BC (Indemnity or Managed Care) - Out of State
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	64	BC (Indemnity or Managed Care) - Unspecified

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	69	BC (Indemnity or Managed Care) - Other
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	71	HMO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	72	PPO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	73	POS
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	79	Other Managed Care, Unknown if public or private
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	81	Self-pay
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	82	No Charge
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	83	Refusal to Pay/Bad Debt
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	84	Hill Burton Free Care
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	85	Research/Donor

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	89	No Payment, Other
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	91	Foreign National
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	92	Other (Non-government)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	93	Disability Insurance
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	94	Long-term Care Insurance
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	95	Worker's Compensation
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	96	Auto Insurance (no fault)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	98	Other specified (includes Hospice - Unspecified plan)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	99	No Typology Code available for payment source
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	111	Medicare HMO

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	112	Medicare PPO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	113	Medicare POS
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	119	Medicare Managed Care Other
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	121	Medicare FFS
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	122	Drug Benefit
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	123	Medicare Medical Savings Account (MSA)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	129	Medicare Non-managed Care Other
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	211	Medicaid HMO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	212	Medicaid PPO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	213	Medicaid PCCM (Primary Care Case Management)

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	219	Medicaid Managed Care Other
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	311	TRICARE (CHAMPUS)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	312	Military Treatment Facility
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	313	Dental --Stand Alone
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	321	Veteran care--Care provided to Veterans
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	322	Non-veteran care
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	331	Indian Health Service - Regular
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	332	Indian Health Service - Contract
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	333	Indian Health Service - Managed Care
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	334	Indian Tribe - Sponsored Coverage

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	341	Title V (MCH Block Grant)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	342	Migrant Health Program
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	343	Ryan White Act
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	349	Other
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	361	State SCHIP program (codes for individual states)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	362	Specific state programs (list/ local code)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	369	State, not otherwise specified (other state)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	371	Local - Managed care
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	372	FFS/Indemnity
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	379	Local, not otherwise specified (other local, county)

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	381	Federal, State, Local not specified managed care
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	382	Federal, State, Local not specified - FFS
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	389	Federal, State, Local not specified - Other
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	511	Commercial Managed Care - HMO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	512	Commercial Managed Care - PPO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	513	Commercial Managed Care - POS
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	514	Exclusive Provider Organization
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	515	Gatekeeper PPO (GPPO)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	519	Managed Care, Other (non HMO)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	521	Commercial Indemnity

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	522	Self-insured (ERISA) Administrative Services Only (ASO) plan
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	523	Medicare supplemental policy (as second payer)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	529	Private health insurance—other commercial Indemnity
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	611	BC Managed Care - HMO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	612	BC Managed Care - PPO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	613	BC Managed Care - POS
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	619	BC Managed Care - Other
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	821	Charity
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	822	Professional Courtesy
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	823	Hispanic or Latino

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	951	Worker's Comp HMO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	953	Worker's Comp Fee-for-Service
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	954	Worker's Comp Other Managed Care
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	959	Worker's Comp, Other unspecified
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3111	TRICARE Prime--HMO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3112	TRICARE Extra--PPO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3113	TRICARE Standard - Fee For Service
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3114	TRICARE For Life--Medicare Supplement
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3115	TRICARE Reserve Select
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3116	Uniformed Services Family Health Plan (USFHP) -- HMO

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3119	Department of Defense - (other)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3121	Enrolled Prime--HMO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3122	Non-enrolled Space Available
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3123	TRICARE For Life (TFL)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3211	Direct Care--Care provided in VA facilities
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3212	Indirect Care--Care provided outside VA facilities
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3221	Civilian Health and Medical Program for the VA (CHAMPVA)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3222	Spina Bifida Health Care Program (SB)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3223	Children of Women Vietnam Veterans (CWVV)
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3229	Other non-veteran care

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3711	HMO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3712	PPO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3713	POS
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3811	Federal, State, Local not specified - HMO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3812	Federal, State, Local not specified - PPO
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3813	Federal, State, Local not specified - POS
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	3819	Federal, State, Local not specified - not specified managed care
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	9999	Unavailable / Unknown
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	32121	Fee Basis
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	32122	Foreign Fee/Foreign Medical Program(FMP)

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	32123	Contract Nursing Home/Community Nursing Home
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	32124	State Veterans Home
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	32125	Sharing Agreements
PHDSC	2.16.840.1.114222.4.11.3591	Payer	Individual Characteristic	Source of Payment Typology	4.0	32126	Other Federal Agency

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Measure Title: HIV/AIDS: Tuberculosis (TB) Screening
Measure Description: Percentage of patients aged 3 months and older with a diagnosis of HIV/AIDS, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection
Measurement Period: 12 Consecutive Months

Phase

Identify Patients in the Intial Patient Population (IPP)	Identify Patients in the Denominator (D)	Identify Patients in Numerator (N)	Identify Patients who have valid Denominator Exceptions (EI)
PATIENT AGE 3 months and older AND DIAGNOSIS, Active HIV AND ENCOUNTER, performed Two or more HIV Visits during measurement year with at least 90 days between each visit	All Patients Identified Within the Initial Patient Population	LABORATORY TEST, Result At least one Tuberculosis (TB) screening since HIV diagnosis OR Procedure, Result At least one finding of tuberculin skin test since HIV diagnosis	MEDICAL REASON Documentation of Medical Reason for not performing a tuberculosis (TB) screening test