THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0

August 2008

The measure information you submit will be shared with NQF's Steering Committees and Technical Advisory Panels to evaluate measures against the NQF criteria of importance to measure and report, scientific acceptability of measure properties, usability, and feasibility. Four conditions (as indicated below) must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards. Not all acceptable measures will be strong—or equally strong—among each set of criteria. The assessment of each criterion is a matter of degree; however, all measures must be judged to have met the first criterion, importance to measure and report, in order to be evaluated against the remaining criteria. References to the specific measure evaluation criteria are provided in parentheses following the item numbers. Please refer to the *Measure Evaluation Criteria* for more information at *www.qualityforum.org* under Core Documents. Additional guidance is being developed and when available will be posted on the NQF website.

Use the tab or arrow (↓→) keys to move the cursor to the next field (or back ←↑). There are three types of response fields:

- drop-down menus - select one response;
- check boxes – check as many as apply; and
- text fields – you can copy and paste text into these fields or enter text; these fields are not limited in size, but in most cases, we ask that you summarize the requested information.

Please note that URL hyperlinks do not work in the form; you will need to type them into your web browser.

Be sure to answer all questions. Fields that are left blank will be interpreted as no or none. Information must be provided in this form. Attachments are not allowed except when specifically requested or to provide additional detail or source documents for information that is summarized in this form. If you have important information that is not addressed by the questions, they can be entered into item #48 near the end of the form.

For questions about this form, please contact the NQF Project Director listed in the corresponding call for measures.

	CONDITIONS FOR CONSIDERATION BY NQF
	Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards.
A (A)	*Public domain or Intellectual Property Agreement signed: IP Agreement signed and submitted (If no, do not submit)* *Template for the Intellectual Property Agreement is available at www.qualityforum.org under Core Documents.*
B (B)	*Measure steward/maintenance: Is there an identified responsible entity and process to maintain and update the measure on a schedule commensurate with clinical innovation, but at least every 3 years?* *Yes, information provided in contact section (If no, do not submit)*
C (C)	*Intended use: Does the intended use of the measure include BOTH public reporting AND quality improvement? Yes (If no, do not submit)*
D (D)	*Fully developed and tested: Is the measure fully developed AND tested? Yes, fully developed and tested (If not tested and no plans for testing within 24 months, do not submit)*

THE NATIONAL QUALITY FORUM

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August 2008

	(for NQF staff use) NQF Review #: EC-003-08 NQF Project: National Voluntary Consensus Standards for Ambulatory Care Using Clinically Enriched Administrative Data
	MEASURE SPECIFICATIONS & DESCRIPTIVE INFORMATION
1	*Information current as of (date- MM/DD/YY): 11/21/08*
2	*Title of Measure:* *APPROPRIATE FOLLOW UP FOR PATIENTS WITH HIV*
3	**Brief description of measure [1]:** To ensure that all members diagnosed with HIV receive at least biannual testing for CD4 and HIV RNA levels to monitor for disease activity.
4 (2a)	**Numerator Statement:** Members who received a CD4 count and an HIV RNA level laboratory test during the 0-6 months after the index date. Note: Index date is defined as the first instance of denominator criteria A **Time Window:** The 0-6 months after the index date. **Numerator Details** (Definitions, codes with description): Numerator Logic: A and B [A] Members who received a CD4 count laboratory test in the 0-6 months after the index date. CPT-4 code(s): 86360, 86361 AND [B] Members who received an HIV RNA level laboratory tests in the 0-6 months after the index date. CPT-4 code(s): 87536, 87539
5 (2a)	**Denominator Statement:** Continuously enrolled members with a diagnosis of HIV during the one year period beginning six months prior to the start of the measurement year. **Time Window:** The one year period beginning six months prior to the start of the measurement year. **Denominator Details** (Definitions, codes with description): Denominator Logic: A and CE [CE] Members who are continuously enrolled during the 0-6 months after the index date. [A] Members with a diagnosis of HIV during the 1 year period beginning 6 months prior to the start of the measurement year. ICD-9 diagnosis code(s): 042, 079.53, V08 DRG code(s): 488, 489, 490

[1] Example of measure description: Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year.

6 (2a, 2d)	**Denominator Exclusions:** N/A **Denominator Exclusion Details** (Definitions, codes with description): N/A
7 (2a, 2h)	**Stratification** Do the measure specifications require the results to be stratified? No ► If "other" describe: **Identification of stratification variable(s):** **Stratification Details** (Definitions, codes with description):
8 (2a, 2e)	**Risk Adjustment** Does the measure require risk adjustment to account for differences in patient severity before the onset of care? No ► **If yes,** (select one) ► Is there a separate proprietary owner of the risk model? (select one) **Identify Risk Adjustment Variables:** **Detailed risk model:** attached ☐ **OR** Web page URL:
9 (2a)	**Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☐ **OR** Web page URL: **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 ► If "Other", please describe:
10 (2a. 4a, 4b)	**Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** **Data dictionary/code table** attached ☐ **OR** Web page URL: **Data Quality** (2a) *Check all that apply* ☐ Data are captured from an authoritative/accurate source (e.g., lab values from laboratory personnel) ☒ Data are coded using recognized data standards ☐ Method of capturing data electronically fits the workflow of the authoritative source ☐ Data are available in EHRs ☐ Data are auditable
11 (2a, 4b)	**Data Source and Data Collection Methods** *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply* ☐ Electronic Health/Medical Record ☐ Electronic Clinical Database, Name: ☐ Electronic Clinical Registry, Name: ☒ Electronic Claims ☐ Electronic Pharmacy data ☐ Electronic Lab data ☒ Electronic source – other, Describe: Member demographics and member enrollment data ☐ Paper Medical Record ☐ Standardized clinical instrument, Name: ☐ Standardized patient survey, Name: ☐ Standardized clinician survey, Name: ☐ Other, Describe: Instrument/survey attached ☐ **OR** Web page URL:
12 (2a)	**Sampling** *If measure is based on a sample, provide instructions and guidance on sample size.* **Minimum sample size:** N/A **Instructions:**
13 (2a)	**Type of Measure:** Process ► If "Other", please describe: ► If part of a composite or paired with another measure, please identify composite or paired measure
14	**Unit of Measurement/Analysis** (*Who or what is being measured*) *Check all that apply.*

(2a)	☐ Can be measured at all levels ☒ Individual clinician (e.g., physician, nurse) ☒ Group of clinicians (e.g., facility department/unit, group practice) ☒ Facility (e.g., hospital, nursing home)	☐ Integrated delivery system ☒ Health plan ☐ Community/Population ☐ Other (*Please describe*):

15	**Applicable Care Settings** *Check all that apply*	
(2a)	☐ Can be used in all healthcare settings ☒ Ambulatory Care (office/clinic) ☐ Behavioral Healthcare ☐ Community Healthcare ☐ Dialysis Facility ☐ Emergency Department ☐ EMS emergency medical services ☒ Health Plan ☐ Home Health	☐ Hospice ☐ Hospital ☐ Long term acute care hospital ☐ Nursing home/ Skilled Nursing Facility (SNF) ☐ Prescription Drug Plan ☐ Rehabilitation Facility ☐ Substance Use Treatment Program/Center ☐ Other (*Please describe*):

	IMPORTANCE TO MEASURE AND REPORT
	Note: This is a threshold criterion. If a measure is not judged to be sufficiently important to measure and report, it will not be evaluated against the remaining criteria.
16 (1a)	**Addresses a Specific National Priority Partners Goal** *Enter the numbers of the specific goals related to this measure (see list of goals on last page)*: N/A
17 (1a)	**If not related to NPP goal, identify high impact aspect of healthcare** severity of illness **Summary of Evidence:** • Revised CDC estimates of HIV prevalence suggest that there were 1.1 million adults and adolescents were living with HIV in the United States at the end of 2006, and increase of 11.% from 2003.[1] • This increase was due in part to the decrease in mortality as a result of highly active antiretroviral treatment (HAART), and because the incidence rate of new HIV infections is now lower than the mortality rate.[1] **Citations[2] for Evidence:** [1] CDC. HIV/AIDS Surveillance 1. Report, 2006. Vol. 18. Atlanta: US Department of Health and Human Services, CDC; 2008. http://www.cdc.gov/hiv.
18 (1b)	**Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.* **Summary of Evidence:** Little is know regarding levels of adherence to HIV clinical guidelines within the United States. Reports which rely on patients seen at a HIV specialty center suggest that CD4 count testing rates are high.[1] However, we were unable to find any studies which detailed overall rates of CD4 testing and RNA testing among a commercially insured population. It is suspected that the population level rates of testing would be lower. **Citations for Evidence:** [1] Kitahata, et al., Electronic human immunodeficiency virus (HIV) clinical reminder system improves adherence to practice guidelines among the University of Washington HIV Study Cohort. Clin Infect Dis, 2003. 36(6): p. 803-11.
19 (1b)	**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.* **Summary of Evidence:** Decreases in mortality associated with the advent of HAART have been smaller and more delayed in women with HIV as compared to men.[1] Women with HIV appear to be disproportionately affected by socioeconomic factors, compared to men; significant risk factors of mortality among women with HIV

[2] Citations can include, but are not limited to journal articles, reports, web pages (URLs).

include unemployment, alcohol abuse and injection drug use, whereas increased mortality in men is most highly associated with higher eduation, depression and promiscuity.[1]

Citations for evidence:

1. Hessol, et al., Mortality among participants in the Multicenter AIDS Cohort Study and the Women's Interagency HIV Study. Clin Infect Dis, 2007. 44(2): p. 287-94.

20 (1c)

If measuring an Outcome Describe relevance to the national health goal/priority, condition, population, and/or care being addressed: N/A

If not measuring an outcome, provide evidence supporting this measure topic and grade the strength of the evidence

Summarize the evidence (including citations to source) supporting the focus of the measure as follows:

- Intermediate outcome – evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit.
- Process – evidence that the measured clinical or administrative process leads to improved health/avoidance of harm and
  if the measure focus is on one step in a multi-step care process, it measures the step that has the greatest effect on improving the specified desired outcome(s).
- Structure – evidence that the measured structure supports the consistent delivery of effective processes or access that lead to improved health/avoidance of harm or cost/benefit.
- Patient experience – evidence that an association exists between the measure of patient experience of health care and the outcomes, values and preferences of individuals/ the public.
- Access – evidence that an association exists between access to a health service and the outcomes of, or experience with, care.
- Efficiency– demonstration of an association between the measured resource use and level of performance with respect to one or more of the other five IOM aims of quality.

Type of Evidence *Check all that apply*

☒ Evidence-based guideline	☐ Quantitative research studies
☐ Meta-analysis	☐ Qualitative research studies
☐ Systematic synthesis of research	☐ Other (*Please describe*):

Overall Grade for Strength of the Evidence[3] (*Use the USPSTF system, or if different, also describe how it relates to the USPSTF system)*: B

Summary of Evidence (*provide guideline information below*):

- The development of highly active antiretroviral therapy has resulted in a significant decrease in disease symptoms, opportunistic infections, hospitalizations and mortality among those infected with HIV.[1]
- The excess mortality rate among HIV infected individuals has declined from 40.8% in 1996 (pre HAART) to 6.1% during 2004-2006.[2]
- The CD4 cell count is used to stage HIV disease, to assess the risk of HIV-associated complications, to gauge the need for prophylaxis against opportunistic infection or initiation of retroviral therapy, and to estimate response to therapy.[3]
- While recommendations exist regarding initiation of antiretroviral therapy based on CD4 levels (treatment is generally initiated at ≤ 200 CD4 cells/µl), HIV RNA levels can also help guide decision-making when CD4 levels are between 200 and 350 cells/µl.[4] Additionally, RNA levels can be used to assess response to therapy.[3]

[3]The strength of the body of evidence for the specific measure focus should be systematically assessed and rated, e.g., USPSTF grading system www.ahrq.gov/clinic/uspstmeth.htm: A - The USPSTF recommends the service. There is high certainty that the net benefit is substantial. B - The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. C - The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. Offer or provide this service only if other considerations support the offering or providing the service in an individual patient. D - The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. I - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

	• The effectiveness of antiretroviral therapy is measured not just by a patient's symptoms but by laboratory parameters such as viral load and CD4 count which may be predictive of prognosis.[5, 6] **Citations for Evidence:** 1. Marschner, I.C., et al., Use of changes in plasma levels of human immunodeficiency virus type 1 RNA to assess the clinical benefit of antiretroviral therapy. J Infect Dis, 1998. 177(1): p. 40-7. 2. Bhaskaran, et al., Changes in the risk of death after HIV seroconversion compared with mortality in the general population. Jama, 2008. 300(1): p. 51-9. 3. Aberg, J.A., et al., Primary care guidelines for the management of persons infected with human immunodeficiency virus: recommendations of the HIV Medicine Association of the Infectious Diseases Society of America. Clin Infect Dis, 2004. 39(5): p. 609-29. 4. Yeni, P., Hammer, SM, Carpenter, CJ, et al., Antiretroviral Treatment for Adult HIV Infection in 2002: Updated Recommendations of the International AIDS Society-USA Panel. JAMA, 2002. 288: p. 222-235. 5. Yeni, P.G., et al., Treatment for Adult HIV Infection: 2004 Recommendations of the International AIDS Society-USA Panel. JAMA, 2004. 292(2): p. 251-265. 6. Losina, E., Effectiveness of Antiretroviral Therapy after Protease Inhibitor Failure: An Analytic Overview. Clinical Infectious Diseases, 2004. 38: p. 1613-1622.
21 (1c)	**Clinical Practice Guideline** *Cite the guideline reference; quote the specific guideline recommendation related to the measure and the guideline author's assessment of the strength of the evidence; and summarize the rationale for using this guideline over others.* **Guideline Citation:** 1. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Bethesda (MD): Department of Health and Human Services (DHHS); 2008 Jan 29. 128 p. 2. Aberg JA, Gallant JE, Anderson J, Oleske JM, Libman H, Currier JS, Stone VE, Kaplan JE. Primary care guidelines for the management of persons infected with human immunodeficiency virus: recommendations of the HIV Medicine Association of the Infectious Diseases Society of America. Clin Infect Dis 2004 Sep 1;39(5):609-29. **Specific guideline recommendation:** • The CDC states that CD4 count should be determinted every three to six months to 1) determine when to start antiretroviral in patients who do not meet the criteria for initiation; (2) assess immunologic response to antiretroviral therapy; and (3) assess the need for initiating chemoprophylaxis for opportunistic infections (level of evidence, A-1) The CDC also states that Plasma HIV RNA is critical for evaluating response to therapy (level of evidence, A-1) and recommends testing plasma viral load every 3-4 months for patients with stable viral suppression (Level of evidence, B-II).[1] • The Infectious Disease Society of America states that Asymptomatic patients with normal CD4 cell counts and low virus loads can be monitored less frequently, repeating viral load measurements every 3-4 months and CD4 cell counts every 3-6 months (B-III).[2] **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)*: Guidelines are embedded in text above. Definitions of Strength of Recommendation are as follows: Strength of Recommendation A. Good evidence to support a recommendation for use; should always be offered B. Moderate evidence to support a recommendation for use; should generally be offered C. Poor evidence to support a recommendation; optional D. Moderate evidence to support a recommendation against use; should generally not be offered E. Good evidence to support a recommendation against use; should never be offered Quality of Evidence I. Evidence from >1 properly randomized, controlled trial II. Evidence from >1 well-designed clinical trial, without randomization; from cohort or case-

controlled analytic studies (preferably from >1 center); from multiple time-series; or from dramatic results from uncontrolled experiments
III. Evidence from opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committee

Rationale for using this guideline over others: The CDC and IDSA are leading organizations in the field of infectious disease whose guidelines are highly regarded within the medical community.

22 (1c) **Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.*

Summary: RNA and CD4 testing may be indicated more frequently than every 3-4 months upon initial diagnosis of HIV, or upon initiation or changing antiretroviral medications.[1,2] The International AIDS Society guideline states that CD4 and viral load testing may occur every 6 months in members who have CD4 counts that are consistently at least 350/µL, if the viral load remains suppressed.[3] However, we feel that more frequent monitoring is appropriate, as the IAS guideline may be targeted to setting where resources are scarce.

Citations:

1. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Bethesda (MD): Department of Health and Human Services (DHHS); 2008 Jan 29. 128 p.
2. Aberg JA, Gallant JE, Anderson J, Oleske JM, Libman H, Currier JS, Stone VE, Kaplan JE. Primary care guidelines for the management of persons infected with human immunodeficiency virus: recommendations of the HIV Medicine Association of the Infectious Diseases Society of America. Clin Infect Dis 2004 Sep 1;39(5):609-29.
3. Hammer, et al., Antiretroviral treatment of adult HIV infection: 2008 recommendations of the International AIDS Society-USA panel. Jama, 2008. 300(5): p. 555-70.

23 (1) **Briefly describe how this measure (as specified) will facilitate significant gains in healthcare quality related to the specific priority goals and quality problems identified above:** With the advent of HAART and subsequent decrease in mortality, HIV is more of a chronic condition than it had been in the past, which increases the importance of regular monitoring. By measuring and improving the rates of both CD4 and RNA testing in HIV patients, we can better ensure that antiretroviral therapy is initiated at the correct time, assess response to antiretroviral therapy and adjust doses in a more efficient manner, and begin chemoprophylaxis for opportunistic infections in a timely manner. Performing these tests in line with the above guidelines has the potential to aviod antiretroviral drug resistance by closely monitoring response to therapy as well as avoiding opportunistic infections and the costs associated with them through appropriate initiation of chemoprophylaxis.

SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Note: Testing and results should be summarized in this form. However, additional detail and reports may be submitted as supplemental information or provided as a web page URL. If a measure has not been tested, it is only potentially eligible for time-limited endorsement.

24 **Supplemental Testing Information:** attached ☐ **OR** Web page URL:

25 (2b) **Reliability Testing**

Data/sample: The algorithm was run on administrative claims data from two geographically discrete commercial health plans, with member sizes between 1.7 and 2.5 million members

Analytic Method: Rates and denominator sizes were calculated on two years of data to test for stability across time. Data from plan A was from 2005 and 2006. Data for plan B was from 2006 and 2007.

Testing Results:

PLAN	YEAR 1 RATE	YEAR 2 RATE	YEAR 1 DENOMINATOR	YEAR 2 DENOMINATOR
A	77.5%	82.1%	466	476
B	80.1%	83.1%	2422	2657

	Interpretation: rates and denominators are stable over time.
26 (2c)	**Validity Testing** **Data/sample:** Step 1: 2006 Data from six geographically diverse commercial health plans were used to generate rates of HIV follow-up testing, according to the algorithm specified above. The size of the included health plans range from 180,000 members, to 2.4 million members. Step 2: Comparison of current numerator (CD4 count plus HIV RNA level) to CD4 count only. **Analytic Method:** Step 1: The algorithm for HIV follow-up was run on all 6 plans. Denominator size and rate were calculated for each plan. Step 2: Rates for the current numerator definition (CD4 count plus HIV RNA level 0-6 months after index date) were compared to those for a numerator definition which required a CD4 count only (Numerator Criteria A only) for three separate commercial plans. **Testing Results:** PART 1: PLAN RATE DENOMINATOR Plan A 49.8% 598 Plan B 65.2% 1660 Plan C 77.5% 466 Plan D 76.6% 457 Plan E 66.4% 1049 Plan F 80.9% 2422 Average Rate: 69.2% Standard Deviation: 11.3% Average Denominator: 1109 Step 2: PLAN RATE(CD4 + HIV RNA) RATE(CD4 ONLY) A 64.2% 80.5% B 80.6% 84.2% C 66.4% 79.6% Interpretation: the majority of HIV patients are receiving a CD4 test within the most conservative timeframe (0-6) recommended by guidelines. However, HIV RNA viral loads are clearly being done at lower rates. The guidelines state that both CD4 and viral loads should be performed every 6 months at a minimum. As HIV viral loads provide additional prognostic value, especially in patients with CD4 cell counts > 250 x 10(6) cells/L.[1] 1. Tarwater, et al., Prognostic value of plasma HIV RNA among highly active antiretroviral therapy users. Aids, 2004. 18(18): p. 2419-23.
27 (2d)	**Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.* **Summary of Evidence supporting exclusion(s):** N/A **Citations for Evidence:** N/A **Data/sample:** N/A **Analytic Method:** N/A

	Testing Results: N/A
28 (2e)	**Risk Adjustment Testing** *Summarize the testing used to determine the need (or no need) for risk adjustment and the statistical performance of the risk adjustment method.* **Data/sample:** N/A **Analytic Method:** **Testing Results:** ►**If outcome or resource use measure not risk adjusted, provide rationale:**
29 (2g)	**Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*) **Data/sample:** N/A **Analytic Method:** **Results:**
30 (2f)	**Provide Measure Results from Testing or Current Use** Results from testing **Data/sample:** See boxes 25 and 26. **Methods to identify statistically significant and practically/meaningfully differences in performance:** **Results:**
31 (2h)	**Identification of Disparities** ►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:** N/A ►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale:
	USABILITY
32 (3)	*Current Use Testing completed If in use, how widely used (select one)* ► *If "other," please describe:* ☐ *Used in a public reporting initiative, name of initiative:* *Sample report attached* ☐ *OR Web page URL:*
33 (3a)	**Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **Data/sample:** Data are reported as rates and denominator size. It was felt that no interpretability testing was needed. Based upon numerous interactions with health plans, performance based on denominator and rate are easily interpreted, as long as the populations captured in numerator, denominator and denominator exclusion are made explicit. **Methods:** **Results:**
34 (3b, 3c)	**Relation to other NQF-endorsed™ measures** ►Is this measure similar or related to measure(s) already endorsed by NQF (on the same topic or the same target population)? *Measures can be found at www.qualityforum.org under Core Documents.* *Check all that apply*

	☐ Have not looked at other NQF measures ☒ Other measure(s) on same topic ☒ Other measure(s) for same target population ☐ No similar or related measures **Name of similar or related NQF-endorsed™ measure(s):** 0404: CD4+ Cell Count - Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with a CD4+ cell count or CD4+ cell percentage performed at least once every 6 months **Are the measure specifications harmonized with existing NQF-endorsed™ measures?** Partially harmonized ►If not fully harmonized, provide rationale: Current U.S. guidelines recommend BOTH CD4 counts and RNA levels be measured every 6 months. RNA levels provide additional prognostic information, and are critical in checking for virological failure of HAART treatments. **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** This measure will allow for the assessment of delivery of BOTH CD4 count and RNA level, which will follow the guidelines recommended by the CDC and the IDSA. RNA levels provide additional prognostic information, and are critical in assesing for virological failure of HAART treatment.
	FEASIBILITY
35 (4a)	*How are the required data elements generated? Check all that apply* ☐ *Data elements are generated concurrent with and as a byproduct of care processes during care delivery (e.g., blood pressure or other assessment recorded by personnel conducting the assessment)* ☐ *Data elements are generated from a patient survey (e.g., CAHPS)* ☒ *Data elements are generated through coding performed by someone other than the person who obtained the original information (e.g., DRG or ICD-9 coding on claims)* ☐ *Other, Please describe:*
36 (4b)	*Electronic Sources All data elements* ►*If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:* ►*Specify the data elements for the electronic health record: ICD-9 diagnosis codes, ICD-9 Proc Codes, CPT-4 codes, HCPCS codes, UB revenue codes, NDC code, DRG codes*
37 (4c)	*Do the specified exclusions require additional data sources beyond what is required for the other specifications? No* ►*If yes, provide justification:*
38 (4d)	*Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure: This is a administrative claims-based quality indicator with certain potential biases, including coding variation between providers and missing data. Nevertheless, administrative claims data is the widely available and has been used to effectively examine and document patterns of health care utilization, detect opportunities to improve quality of care, estimate incidence of disease, and even assess outcomes of pharmaceutical, radiological, and surgical procedures.* *Describe how could these potential problems be audited: HBI has developed an online tool (currently in use by several health plans), which allows physicians the opportunity to supplement their quality scores through self-report via a secured web site. Via this website, physicians are able to identify specific patients with whom they had an office visit during the measurement period and who reportedly did not have the indicated quality care. Physicians can then review their charts to verify whether in fact the quality care was performed. The physician can then manually enter corrections to the patient record via the website, indicating that the quality care was done. This data is subject to clinical review prior to acceptance. The hybrid quality score (via administrative claims and self report) can be updated on a quarterly basis.* *Did you audit for these potential problems during testing? No If yes, provide results:*

39 (4e)	*Testing feasibility Describe what have you learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:* *BURDEN ASSOCIATED WITH DATA COLLECTION: Administrative claims data are automatically collected by commercial health plans.*
	CONTACT INFORMATION
40	*Web Page URL for Measure Information Describe where users (implementers) should go for more details on specifications of measures, or assistance in implementing the measure.* *Web page URL: N/A*
41	**Measure Intellectual Property Agreement Owner Point of Contact** **First Name:** Zak **MI:** **Last Name:** Ramadan-Jradi **Credentials (MD, MPH, etc.):** MD, MPH **Organization:** Health Benchmarks® **Street Address:** 21650 Oxnard St., Suite 550 **City:** Woodland Hills **State:** CA **ZIP:** 91367-7806 **Email:** zramadan@us.imshealth.com **Telephone:** 818-676-2820 ext:
42	**Measure Submission Point of Contact** **If different than IP Owner Contact** **First Name:** Karen **MI:** **Last Name:** Hsu **Credentials (MD, MPH, etc.):** MPH, MBA **Organization:** Health Benchmarks® **Street Address:** 21650 Oxnard St., Suite 550 **City:** Woodland Hills **State:** CA **ZIP:** 91367-7806 **Email:** khsu@us.imshealth.com **Telephone:** 541-550-7983 ext:
43	**Measure Developer Point of Contact** **If different than IP Owner Contact** **First Name:** Judy **MI:** Y **Last Name:** Chen **Credentials (MD, MPH, etc.):** MD, MSHS **Organization:** Health Benchmarks® **Street Address:** 21650 Oxnard St., Suite 550 **City:** Woodland Hills **State:** CA **ZIP:** 91367-7806 **Email:** judy.chen@us.imshealth.com **Telephone:** 818-676-2883 ext:
44	**Measure Steward Point of Contact** **If different than IP Owner Contact** *Identifies the organization that will take responsibility for updating the measure and assuring it is consistent with the scientific evidence and current coding schema; the steward of the measure may be different than the developer.* **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:** **Email:** **Telephone:** ext
	ADDITIONAL INFORMATION
45	**Workgroup/Expert Panel involved in measure development** No workgroup or panel used ►If workgroup used, describe the members' role in measure development: ►Provide a list of workgroup/panel members' names and organizations:
46	*Measure Developer/Steward Updates and Ongoing Maintenance* *Year the measure was first released: 2008* *Month and Year of most recent revision: January, 2008* *What is the frequency for review/update of this measure? Annually* *When is the next scheduled review/update for this measure? January, 2009*
47	**Copyright statement/disclaimers:** © 2008 Health Benchmarks® Confidential and Proprietary All Rights Reserved
48	**Additional Information:**
49	**I have checked that the submission is complete and any blank fields indicate that no information is provided.**☒
50	**Date of Submission** (*MM/DD/YY*)**:** 11/21/08

PATIENT & FAMILY ENGAGEMENT

PRIORITY STATEMENT: Engage Patients and Their Families in Managing Their Health and Making Decisions About Their Care

1.1. All providers will routinely solicit and publicly report on their patients' perspectives of care

1.2. All providers will work collaboratively with their patients to assist them in making informed decisions about treatment options consistent with their values and preferences

POPULATION HEALTH

PRIORITY STATEMENT: IMPROVE THE HEALTH OF THE U.S. POPULATION

2.1. The population will be up to date on all high-priority age- and gender-appropriate evidence-based clinical preventive services

2.2. The population will receive recommended evidence-based interventions to improve targeted healthy lifestyle behaviors

2.3. All communities will demonstrate a 10% improvement in their community index of health

2.4. Americans will have all recommended high priority healthy lifestyle behaviors under control

SAFETY

PRIORITY STATEMENT: IMPROVE THE SAFETY OF THE U.S. HEALTH CARE SYSTEM

3.1. All providers will drive all preventable healthcare-associated infections (HAI) to zero

3.2. All providers will drive the incidence of preventable NQF Serious Reportable Events (SRE) to zero

3.3. All hospitals will reduce preventable and premature mortality rates to best-in-class

3.4. All hospitals and their community partners will reduce 30-day mortality rates following hospitalization for select conditions to best-in-class

PALLIATIVE CARE

PRIORITY STATEMENT: GUARANTEE APPROPRIATE AND COMPASSIONATE CARE FOR PATIENTS WITH LIFE-LIMITING ILLNESSES

4.1. All providers will identify, document, and effectively treat physical symptoms (e.g. pain, shortness of breath, constipation, others) at levels acceptable to patients with a life-limiting illness

4.2. All providers will effectively address the psychosocial and spiritual needs of patients with life-limiting illnesses and their families according to their preferences

4.3. All eligible patients will receive high quality palliative care and hospice services

CARE COORDINATION

PRIORITY STATEMENT: ENSURE PATIENTS RECEIVE WELL-COORDINATED CARE ACROSS ALL PROVIDERS, SETTINGS, AND LEVELS OF CARE

5.1. All providers will accurately and completely reconcile medications across the continuum of care (i.e. admission, transfer within and between care providers, discharge, and outpatient appointments) and ensure communication with the next provider of services

5.2. All inpatient and outpatient providers will assess the patient's perspective of the coordination of their care using a validated care coordination survey tool

5.3. All providers will reduce 30-day all-cause readmission rates resulting from poorly coordinated care to best-in-class

5.4. All providers will reduce preventable emergency department (i.e. those that could be avoided with timely access to primary care) visits resulting from poorly coordinated care by 50%

PATIENT-FOCUSED CARE

PRIORITY STATEMENT: GUARANTEE HIGH VALUE CARE ACROSS ACUTE AND CHRONIC EPISODES

6.1. All patients will receive high-value care over the course of their acute or chronic illness

OVERUSE

PRIORITY STATEMENT: ELIMINATE WASTE WHILE ENSURING THE DELIVERY OF APPROPRIATE CARE

7.1. Reduce wasteful and inappropriate care for the top ten targeted areas by 50%

THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0
August 2008

The measure information you submit will be shared with NQF's Steering Committees and Technical Advisory Panels to evaluate measures against the NQF criteria of importance to measure and report, scientific acceptability of measure properties, usability, and feasibility. Four conditions (as indicated below) must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards. Not all acceptable measures will be strong—or equally strong—among each set of criteria. The assessment of each criterion is a matter of degree; however, all measures must be judged to have met the first criterion, importance to measure and report, in order to be evaluated against the remaining criteria. References to the specific measure evaluation criteria are provided in parentheses following the item numbers. Please refer to the *Measure Evaluation Criteria* for more information at *www.qualityforum.org* under Core Documents. Additional guidance is being developed and when available will be posted on the NQF website.

Use the tab or arrow (↓→) keys to move the cursor to the next field (or back ←↑). There are three types of response fields:

- drop-down menus - select one response;
- check boxes – check as many as apply; and
- text fields – you can copy and paste text into these fields or enter text; these fields are not limited in size, but in most cases, we ask that you summarize the requested information.

Please note that URL hyperlinks do not work in the form; you will need to type them into your web browser.

Be sure to answer all questions. Fields that are left blank will be interpreted as no or none. Information must be provided in this form. Attachments are not allowed except when specifically requested or to provide additional detail or source documents for information that is summarized in this form. If you have important information that is not addressed by the questions, they can be entered into item #48 near the end of the form.

For questions about this form, please contact the NQF Project Director listed in the corresponding call for measures.

	CONDITIONS FOR CONSIDERATION BY NQF
	Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards.
A (A)	*Public domain or Intellectual Property Agreement signed: IP Agreement signed and submitted (If no, do not submit)* *Template for the Intellectual Property Agreement is available at www.qualityforum.org under Core Documents.*
B (B)	*Measure steward/maintenance: Is there an identified responsible entity and process to maintain and update the measure on a schedule commensurate with clinical innovation, but at least every 3 years? Yes, information provided in contact section (If no, do not submit)*
C (C)	*Intended use: Does the intended use of the measure include BOTH public reporting AND quality improvement? Yes (If no, do not submit)*
D (D)	*Fully developed and tested: Is the measure fully developed AND tested? Yes, fully developed and tested (If not tested and no plans for testing within 24 months, do not submit)*

THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0
August 2008

	(for NQF staff use) NQF Review #: EC-009-08 NQF Project: National Voluntary Consensus Standards for Ambulatory Care Using Clinically Enriched Administrative Data
	MEASURE SPECIFICATIONS & DESCRIPTIVE INFORMATION
1	*Information current as of (date- MM/DD/YY): 11/21/08*
2	*Title of Measure: HIV SCREENING: MEMBERS AT HIGH RISK OF HIV*
3	**Brief description of measure [1]:** To ensure that members at increased risk of HIV infection be screened for HIV
4 (2a)	**Numerator Statement:** Members who received a HIV test or HIV rapid test in the 60 days prior through 60 days after the index date. Note: Index date is defined as the first instance of denominator crieteria A or B or C or D or E or F. **Time Window:** 60 days prior through 60 days after the index date **Numerator Details** (Definitions, codes with description): Numerator Logic: A or B [A] Members with at least one instance of HIV screening 60 days prior through 60 days after the index date. Human immunodeficiency virus (HIV) counseling: ICD-9 diagnosis code(s): V65.44 HIV-1 Screening Test: CPT-4 code(s): 86689, 86701,86703, 87390, 87534-87536, S3645, 0023T* HIV-2 Screening Test: CPT-4 code(s): 86702, 87391, 87537-87539 [B] Members with at least one instance of HIV rapid test screening during the period starting 60 days prior through 60 days after the index date. HIV-1 Screening Test CPT-4 code(s): 86701, 86703 AND CPT-4 modifier code(s): 92
5 (2a)	**Denominator Statement:** Continuously enrolled members 14-64 years of age by the end of the measurement year, who have been screened, diagnosed or treated for an STD other than HIV, members who are being screened for Hepatitis C, or sexually active women, ages 14-24 with abortion or miscarriage. **Time Window:** 1 year period ending 60 days prior to end of measurement year **Denominator Details** (Definitions, codes with description): Denominator Logic: A or B or (C and GENDER1 and DEMO2) or ((D or E or F) and GENDER2 and DEMO1)) and DEMO2 and CE

[1] Example of measure description: Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year.

[DEMO1] Women ages 14-24 years by the end of the measurement year

[DEMO2] Member ages 14-64 years by the end of the measurement year

[GENDER1] Males

[GENDER2] Females

[CE] Members who were continuously enrolled 365 days prior to through 60 days after the index date.

STDs for this indicator include: Bacterial Vaginosis, Chancroid, Chlamydia, condyloma, epididymitis, Gonorrhea (Nesisseria), Granuloma inguinale, Hepatitis B, Herpes, HPV (Human papilloma virus), LGV (lymphgranuloma venereum), NGU (non-gonococcal urethritis), PID (pelvic inflammatory disease), syphilis, Trichomonas vaginalis. Although Hepatitis C is not efficiently transmitted sexually, persons are at risk of Hepatitis C through injection-drug use, and thus at high risk for HIV.

Note: Index date is defined as the first instance of denominator crieteria A or B or C or D or E or F.

[A] Diagnosis of an STD during the 1 year period ending 60 days prior to end of measurement year.

ICD-9 diagnosis code(s):
Chancroid: 099.0
Chlamydia: V73.88, V73.98, 099.5x
Condyloma: 078.11
Epididymitis: 604.9x
Gonococcal infection: 098.xx
Granuloma inguinale: 099.2
Acute Hepatitis B&C: 070.20, 070.21, 070.30, 070.31, 070.51
Herpes: 054.1x
HPV: 079.4, 795.05, 795.09
NGU: 099.1, 099.3, 099.4x, 099.8, 099.9
Pelvic inflammatory disease: 614.0, 614.3, 614.5, 615.0
Syphillis: 091.xx
Trichomonas: 131.xx
Other: V01.6, V65.45, V74.5

[B] Screening test for all STDs except for Gonorrhea and Chlamydia in the 1 year period ending 60 days prior to the end of the measurement year.

CPT code(s):
Trichomonas vaginalis: 87808, 87810, 87850, 87660
Herpes simplex virus II: 87273, 87528, 87529, 87530
Syphilis tests: 87164, 86781, 86592, 86593
Lymphogranuloma venereum: 86729
Hepatitis B or C: 80074, 86704-86707, 86803, 86804, 87340, 87341, 87350, 87515, 87516, 87517, 87520-87522

[C] Screening test for Chlamydia and Gonorrhea in the 1 year period ending 60 days prior to the end of the measurement year. Of note, this step is only paired with male gender because providers may be just sending routine screening for Chlamydia and Gonorrhea for women at the routine Pap visit.

CPT code(s):86631, 86632, 87110, 87270, 87320, 87490-87492, 87590-87592, 87810

[D] Women with abortion or miscarriage in the 1 year period ending 60 days prior to the end of the measurement year.

	CPT Code(s): 01964*, 01965, 01966, 59812, 59820, 59821, 59830, 59840, 59841, 59850-59852, 59855, 59856, 59857, HSPC Code(s): S0199, S2227, S2260, S2262, S2265, S2266, S2267 ICD9-surgical procedure codes: 69.01, 69.51, 74.91, 75.0 DRG code(s): 380, 381 MS-DRG code(s): 779 [E] Women with diagnosis of abortion or miscarriage during the 1 year period ending 60 days prior to the end of the measurement year. ICD9-code(s) 634.xx, 635.xx, 636.xx, 637.xx ,638.xx, 639.x, 779.6 AND Outpatient setting: CPT-4 code(s): 99201-99205, 99211-99215, 99241-99245, 99271-99275, 99301-99313, 99315-99316, 99318-99337, 99341-99350, 99354-99355, 99381-99387, 99391-99397, 99401-99429, 99450, 99455-99456 UB revenue code(s): 0500-0529, 0570-0599, 0770-0779, 0820-0859, 0882, 0982-0983 Inpatient setting: CPT-4 code(s): 99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99291-99300, 99356-99357, 99431-99440 UB revenue code(s): 0100-0114, 0117-0124, 0127-0134, 0137-0144, 0147-0154, 0157-0159, 0160-0169, 0220-0229, 0190-0219, 0720-0729, 0800-0809, 0987 Hospital observation: CPT-4 code(s): 99217-99220, 99234-99236 Emergency room: CPT-4 code(s): 99281-99285 UB revenue code(s): 045x, 0981 [F] Women who used mifepristone during the 1 year period ending 60 days prior to the end of the measurement year. * Codes are retired, but are appropriate for retrospective analysis
6 (2a, 2d)	**Denominator Exclusions:** Members diagnosed with HIV before or on the index date. Note: Index date is defined as the first instance of denominator criteria A or B or C or D or E or F. **Denominator Exclusion Details** (Definitions, codes with description): Denominator Exclusion Logic: A [A] HIV or AIDS ICD-9 diagnosis code(s): 042, 079.53, V08 DRG code(s): 488, 489, 490 MS-DRG code(s): 969, 970, 974, 975, 976, 977
7 (2a, 2h)	**Stratification** Do the measure specifications require the results to be stratified? No ► If "other" describe: **Identification of stratification variable(s):** **Stratification Details** (Definitions, codes with description):
8	**Risk Adjustment** Does the measure require risk adjustment to account for differences in patient severity before the onset of care? No ► **If yes,** (select one)

(2a, 2e)	► Is there a separate proprietary owner of the risk model? (select one) **Identify Risk Adjustment Variables:** **Detailed risk model:** attached ☐ **OR** Web page URL:
9 (2a)	**Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☐ **OR** Web page URL: **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 ► If "Other", please describe:
10 (2a. 4a, 4b)	**Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** **Data dictionary/code table** attached ☐ **OR** Web page URL: **Data Quality** (2a) *Check all that apply* ☐ Data are captured from an authoritative/accurate source (e.g., lab values from laboratory personnel) ☒ Data are coded using recognized data standards ☐ Method of capturing data electronically fits the workflow of the authoritative source ☐ Data are available in EHRs ☐ Data are auditable
11 (2a, 4b)	**Data Source and Data Collection Methods** *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply* ☐ Electronic Health/Medical Record ☐ Electronic Clinical Database, Name: ☐ Electronic Clinical Registry, Name: ☒ Electronic Claims ☐ Electronic Pharmacy data ☐ Electronic Lab data ☒ Electronic source – other, Describe: Member demographics and member enrollment data ☐ Paper Medical Record ☐ Standardized clinical instrument, Name: ☐ Standardized patient survey, Name: ☐ Standardized clinician survey, Name: ☐ Other, Describe: Instrument/survey attached ☐ **OR** Web page URL:
12 (2a)	**Sampling** *If measure is based on a sample, provide instructions and guidance on sample size.* **Minimum sample size:** **Instructions:**
13 (2a)	**Type of Measure:** Process ► If "Other", please describe: ► If part of a composite or paired with another measure, please identify composite or paired measure
14 (2a)	**Unit of Measurement/Analysis** (*Who or what is being measured*) *Check all that apply.* ☐ Can be measured at all levels ☒ Individual clinician (e.g., physician, nurse) ☒ Group of clinicians (e.g., facility department/unit, group practice) ☐ Facility (e.g., hospital, nursing home) ☐ Integrated delivery system ☒ Health plan ☒ Community/Population ☐ Other (*Please describe*):
15 (2a)	**Applicable Care Settings** *Check all that apply* ☐ Can be used in all healthcare settings ☒ Ambulatory Care (office/clinic) ☐ Behavioral Healthcare ☒ Community Healthcare ☐ Dialysis Facility ☒ Emergency Department ☐ EMS emergency medical services ☐ Health Plan ☐ Home Health ☐ Hospice ☐ Hospital ☐ Long term acute care hospital ☐ Nursing home/ Skilled Nursing Facility (SNF) ☐ Prescription Drug Plan ☐ Rehabilitation Facility ☐ Substance Use Treatment Program/Center ☐ Other (*Please describe*):

	IMPORTANCE TO MEASURE AND REPORT
	Note: This is a threshold criterion. If a measure is not judged to be sufficiently important to measure and report, it will not be evaluated against the remaining criteria.
16 (1a)	**Addresses a Specific National Priority Partners Goal** *Enter the numbers of the specific goals related to this measure (see list of goals on last page)*: N/A
17 (1a)	**If not related to NPP goal, identify high impact aspect of healthcare** severity of illness **Summary of Evidence:** Revised CDC estimates of HIV prevalence suggest that there were 1.1 million adults and adolescents living with HIV in the United States at the end of 2006, and increase of 11.% from 2003.[1] This increase was due in part to the decrease in mortality as a result of highly active antiretroviral treatment (HAART), and because the incidence rate of new HIV infections is now lower than the mortality rate.[1] **Citations[2] for Evidence:** [1] CDC. HIV/AIDS Surveillance 1. Report, 2006. Vol. 18. Atlanta: US Department of Health and Human Services, CDC; 2008. http://www.cdc.gov/hiv.
18 (1b)	**Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.* **Summary of Evidence:** The U.S. based literature on HIV testing rates among patients being screened for STDs or who tested positive for HIV is scant. A 2007 study by Tao et al. reported on rates of HIV among patients who coded as having high-risk sexual behavior (ICD-9 code V69.2); men with HRSB had a HIV testing rate of 79.3%, but women were tested for HIV only 38.8% of the time in the internal medicine setting and 30.5% of the time in the ob/gyn setting.[1] However, it is likely that th ICD-9 code for high risk sexual behavior is rarely used by medical providers. In addition, the high HIV screening rate among men with V69.2 codes (as compared to women) reported by Tso et al. suggest that may be disproportionately used to identify men who have sex with men, as opposed to other high-risk sexual behavior. Tao et al. identified a total of 1074 patients with ICD-9 claims codes for V69.2 out of a sample set of 5 million commercially insured members (0.2%). While the Tao et al.'s methodology likely has high specificity, (i.e., the members coded with high-risk sexual behavior likely are at true high risk of STD transmission), the methodology clearly under-identifies patients at risk for sexual transmission of disease. Several studies on STD management suggest that physician compliance to STD guidelines is low.[2,3] In the 2008 Nation Summit on HIV Diagnosis, Prevention, and Access to Care, Dr. Branson for the Center for Disease Control and Prevention, presented the rate of HIV screening members who had complaint of STD from 2002 National Health Inteview Survey was 21%.[4] **Citations for Evidence:** 1. Tao, G. and K.L. Irwin, Receipt of HIV and STD testing services during routine general medical or gynecological examinations: variations by patient sexual risk behaviors. Sex Transm Dis, 2008. 35(2): p. 167-71. 2. McCree, et al., National survey of doctors' actions following the diagnosis of a bacterial STD. Sex Transm Infect, 2003. 79(3): p. 254-6. 3. Lawrence, S., et al., STD screening, testing, case reporting, and clinical and partner notification practices: a national survey of US physicians. Am J Public Health, 2002. 92(11): p. 1784-8. 4. Branson, B. Overview of Routine/expanded HIV Testing in the US. 2008 National Summit on HIV Diagnosis, Prevention, and Access to Care.
19 (1b)	**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.* **Summary of Evidence:** We conducted a study titled "HIV Screening Among Privately Insured Members at High Risk of Acquiring HIV Infection" based on this indicator.[1] We used 2006 administrative claims data for 8 US health plans, with

[2] Citations can include, but are not limited to journal articles, reports, web pages (URLs).

	a total of 7.8 million insured lives. Our study sample consists of continuously enrolled members 14-64 years who have been screened, diagnosed, or treated for an STD (i.e., chancroid, chlamydia, gonorrhea, epididymitis, granuloma inguinale, herpes, human papillomavirus, non-gonococcal urethritis, syphilis, and trichomonas), or hepatitis B or C, and women ages 14-24 who had an abortion/miscarriage (n=259,961). We excluded members with a history of HIV. We assessed HIV screening rates in the 60 days prior to and after the presenting event (120 days total) and examined factors associated with receipt of HIV screening using multivariate analyses. Overall, 36% of members in this study were screened for HIV. Cohort size and HIV screening rates were as follows: STD only (138,425; 18%), hepatitis only (59,707; 23%), abortion/miscarriage only (753; 10%); STD and hepatitis (59,997; 86%), STD and abortion/miscarriage (797; 33%), hepatitis and abortion/miscarriage (13; 54%), and STD, hepatitis, and abortion/miscarriage (269; 93%). Multivariate analyses revealed that women were less likely to be screened than men (OR 0.9, 95% CI 0.8-0.9, $p < 0.001$). Members 18 to 50 years were more likely to be screened than members 14 to 17 (OR 1.2, 95% CI 1.1-1.3, $p < 0.001$), but members 51-64 were less likely to be screened than members 14 to 17 (OR 0.5, 95% CI 0.4-0.5, $p < 0.001$). Members treated in emergency rooms (ER) were less likely to be screened than members seen in other settings (OR 0.86, 95% CI 0.85-0.87, $p < 0.001$). **Citations for evidence:** 1. Chen JY, Tian H, Dahlin-Lee E, Everhad F, Mayer K. HIV Screening among Privately Insured Members at High Risk of Acquiring HIV Infection. 2008 National Summit on HIV Diagnosis, Prevention and Access to Care. Novebmer 19-21, 2008. Crystal City, VA.
20 (1c)	**If measuring an Outcome** Describe relevance to the national health goal/priority, condition, population, and/or care being addressed: N/A **If not measuring an outcome, provide evidence supporting this measure topic and grade the strength of the evidence** *Summarize the evidence (including citations to source) supporting the focus of the measure as follows:* • Intermediate outcome – evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit. • Process – evidence that the measured clinical or administrative process leads to improved health/avoidance of harm and if the measure focus is on one step in a multi-step care process, it measures the step that has the greatest effect on improving the specified desired outcome(s). • Structure – evidence that the measured structure supports the consistent delivery of effective processes or access that lead to improved health/avoidance of harm or cost/benefit. • Patient experience – evidence that an association exists between the measure of patient experience of health care and the outcomes, values and preferences of individuals/ the public. • Access – evidence that an association exists between access to a health service and the outcomes of, or experience with, care. • Efficiency– demonstration of an association between the measured resource use and level of performance with respect to one or more of the other five IOM aims of quality. **Type of Evidence** *Check all that apply* ☒ Evidence-based guideline ☐ Quantitative research studies ☐ Meta-analysis ☐ Qualitative research studies ☐ Systematic synthesis of research ☐ Other (*Please describe*): **Overall Grade for Strength of the Evidence**[3] (*Use the USPSTF system, or if different, also describe how it relates to the USPSTF system)*: A

[3]The strength of the body of evidence for the specific measure focus should be systematically assessed and rated, e.g., USPSTF grading system www.ahrq.gov/clinic/uspstmeth.htm: A - The USPSTF recommends the service. There is high certainty that the net benefit is substantial. B - The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. C - The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. Offer or provide this service only if other considerations support the offering or providing the service in an individual patient. D - The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. I - The USPSTF concludes that

Summary of Evidence (*provide guideline information below*)**:**
Reason for Indicated Intervention or Treatment:

• Presence of STDs may facilitate vascular entry of the HIV virus. STDs may result in mucosal inflammation and cervical friability, decreasing the barrier to vascular entry.[1] The presence of STDs such as chlamydia and syphilis induce a lymphocytic response in the affected area.[2-5] Recruitment of CD4 lymphocytes into areas exposed to HIV may facilitate infection.[6]
• STDs may also increase the level of exposure to HIV during intercourse [7-10]; HIV has been cultured from genital ulcers in patients with coexisting HIV and genital ulcer disease.[11] HIV replication is potentiated by presence of the herpes simplex virus (HSV). Additionally infection with gonorrhea increases HIV shedding by 100 fold in HIV infected men.[12]

Evidence Supporting Intervention or Treatment:
• Prompt diagnosis of HIV is essential for two main reasons. First, the development of highly active antiretroviral therapy in the 1990's has resulted in a significant decrease in disease symptoms, opportunistic infections, hospitalizations and mortality among those infected with HIV.[13] Second, early diagnosis of HIV enables health care providers to counsel patients and refer them to appropriate social support services to help prevent HIV transmission to others. However, recent reports indicate that survival gains from antiretroviral therapy prolongs infectious lifetime and may be associated with sexual risk-taking,[14] calling into question the magnitude of the decrease in transmission risk .
• The USPSTF also found good evidence that appropriately timed interventions, particularly highly active antiretroviral therapy (HAART), lead to improved health outcomes for many of those screened, including reduced risk for clinical progression and reduced mortality.[15]
• Paltiel et al found in 2006 that the clinical and economic benefit of routine screening of adults for HIV in the United States would outweigh the likely harm at the HIV prevalence threshold of 0.20%.[14]

Citations for Evidence:
1. Kreiss, et al., Association between cervical inflammation and cervical shedding of human immunodeficiency virus DNA. J Infect Dis, 1994. 170(6): p. 1597-601.
2. Jacobs, et al., Emergence of multiply resistant pneumococci. N Engl J Med, 1978. 299(14): p. 735-40.
3. Kobayashi, et al., Functional attributes of mucosal immunity in cervical intraepithelial neoplasia and effects of HIV infection. Cancer Res, 2004. 64(18): p. 6766-74.
4. Fleming, et al., From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. Sex Transm Infect, 1999. 75(1): p. 3-17.
5. Humphreys, et al., Evolution of the cutaneous immune response to experimental Haemophilus ducreyi infection and its relevance to HIV-1 acquisition. J Immunol, 2002. 169(11): p. 6316-23.
6. Pudney, et al., Immunological microenvironments in the human vagina and cervix: mediators of cellular immunity are concentrated in the cervical transformation zone. Biol Reprod, 2005. 73(6): p. 1253-63.
7. Buchacz, et al., Syphilis increases HIV viral load and decreases CD4 cell counts in HIV-infected patients with new syphilis infections. Aids, 2004. 18(15): p. 2075-9.
8. Sadiq, et al., The effects of urethritis on seminal plasma HIV-1 RNA loads in homosexual men not receiving antiretroviral therapy. Sex Transm Infect, 2005. 81(2): p. 120-3.
9. Powers, et al., Rethinking the heterosexual infectivity of HIV-1: a systematic review and meta-analysis. Lancet Infect Dis, 2008. 8(9): p. 553-63.
10. Freeman, et al., Herpes simplex virus 2 infection increases HIV acquisition in men and women: systematic review and meta-analysis of longitudinal studies. Aids, 2006. 20(1): p. 73-83.
11. JK, K., et al., Isolation of human immunodeficiency virus from genital ulcers in Nairobi prostitutes. Journal of Infectious Diseases, 1989. 160: p. 380-384.
12. Moss, et al., Human immunodeficiency virus DNA in urethral secretions in men: association with gonococcal urethritis and CD4 cell depletion. J Infect Dis, 1995. 172(6): p. 1469-74.
13. Marschner, et al., Use of changes in plasma levels of human immunodeficiency virus type 1 RNA to assess the clinical benefit of antiretroviral therapy. J Infect Dis, 1998. 177(1): p. 40-7.
14. Paltiel, et al., Expanded HIV screening in the United States: effect on clinical outcomes, HIV

the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

	transmission, and costs. Ann Intern Med, 2006. 145(11): p. 797-806. 15. Chou, et al., Screening for Human Immunodeficiency Virus: Focused Update of a 2005 Systematic Evidence Review for the U. S. Preventive Services Task Force, in AHRQ Quality Indicators. 2007, Agency for Healthcare Research and Quality: Maryland. p. 36.
21 (1c)	**Clinical Practice Guideline** *Cite the guideline reference; quote the specific guideline recommendation related to the measure and the guideline author's assessment of the strength of the evidence; and summarize the rationale for using this guideline over others.* **Guideline Citation:** 1. Chou, R., et al., Screening for HIV: a review of the evidence for the U.S. Preventive Services Task Force. Ann Intern Med, 2005. 143(1): p. 55-73. 2. Workowski, K.A. and S.M. Berman, Sexually transmitted diseases treatment guidelines, 2006. MMWR Recomm Rep, 2006. 55(RR-11): p. 1-94. 3. Committee on Pediatric AIDS and Committee on Adolescents. Adolescents and human immunodeficiency virus: the role of the pediatrician in prevention and intervention. Pediatrics 2001;107:188-90. **Specific guideline recommendation:** • The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen for human immunodeficiency virus (HIV) in all adolescents and adults at increased risk for HIV infection (A-Level Recommendation). Individuals at high risk includes individuals who presents with an STD or seen in STD clinics.[1] • The CDC recommends that all patients seeking treatment for STDs should be screened for HIV each time the patient presents with a new complaint, regardless of whether the patient is known or suspected to have specific behavior risks for HIV infection (No Level of Evidence Specified).[2] • Since a third of all new HIV transmission in the US occurs in people ages 13-24, generally via sexual transmission, the American Academy of Pediatrics recommends that all sexually active adolescents be routinely screened for HIV." (No level of evidence specified)[3] **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)***:** Guideline Ratings are embedded in recommendations above. **Rationale for using this guideline over others:** The USPSTF, CDC and AAP are all highly regarded organizations within the medical community, and their guidelines are widely accepted.
22 (1c)	**Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.* **Summary:** Arguments against screening for HIV are primarily economic. However, routine HIV screening is cost-effective in settings where HIV prevalence is as low as 0.2%.[1] The CDC further argues for routine screening for all members regardless of risk factors.[2] **Citations:** 1. Paltiel, et al., Expanded HIV screening in the United States: effect on clinical outcomes, HIV transmission, and costs. Ann Intern Med, 2006. 145(11): p. 797-806. 2. Centers for Disease Control and Prevention. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR 2006;55(RR-14):1-17
23 (1)	**Briefly describe how this measure (as specified) will facilitate significant gains in healthcare quality related to the specific priority goals and quality problems identified above:** The USPSTF "… found good evidence that both standard and U.S. Food and Drug Administration (FDA)-approved rapid screening tests accurately detect HIV infection. The USPSTF also found good evidence that appropriately timed interventions, particularly highly active antiretroviral therapy (HAART), lead to improved health outcomes for many of those screened, including reduced risk for clinical progression and reduced mortality. Since false-positive test results are rare, harms associated with HIV screening are minimal. Potential harms of true-positive test results include increased anxiety, labeling, and effects on close relationships. Most adverse events associated with HAART, including metabolic disturbances associated with an increased risk for cardiovascular events, may be ameliorated by changes in regimen or appropriate treatment. The USPSTF concluded that the benefits of screening individuals at increased risk substantially outweigh potential harms." Statement from USPSTF which succinctly summarized the

	significant gains in healthcare quality related to this specific measure can be found a the website: http://www.ahrq.gov/clinic/uspstf/uspshivi.htm
	SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES
	Note: Testing and results should be summarized in this form. However, additional detail and reports may be submitted as supplemental information or provided as a web page URL. If a measure has not been tested, it is only potentially eligible for time-limited endorsement.
24	**Supplemental Testing Information:** attached ☐ **OR** Web page URL:
25 (2b)	**Reliability Testing** **Data/sample:** 2006 and 2007 Data from three geographically diverse commercial health plans (70% PP0/30% HMO) were used to generate rates of screening for HIV. **Analytic Method:** The algorithm for HIV testing was run on 2006 and 2007 data from the three plans in order to assess stability of the measure over time. **Testing Results:** PLAN 2006 RATE 2007 RATE 2006 DENOMINATOR 2007 DENOMINATOR A 30.8% 32.3% 39,069 40,983 B 25.7% 26.5% 8,672 8,567 C 34.7% 34.4% 29,978 29,736 The denominator size and rates are stable across 2 years for 3 plans.
26 (2c)	**Validity Testing** **Data/sample:** We used 2006 administrative claims data for 8 US health plans, with a total of 7.8 million insured lives. **Analytic Method:** Our study sample consists of continuously enrolled members 14-64 years who have been screened, diagnosed, or treated for an STD (i.e., chancroid, chlamydia, gonorrhea, epididymitis, granuloma inguinale, herpes, human papillomavirus, non-gonococcal urethritis, syphilis, and trichomonas), or hepatitis B or C , and women ages 14-24 with abortion/miscarriage (n=259,961). We excluded members with a history of HIV. We assessed HIV screening rates in the 60 days prior to and after the presenting event (120 days total) and examined factors associated with receipt of HIV screening using multivariate analyses. **Testing Results:** Results: Overall, 36% of members in this study were screened for HIV. Cohort size and HIV screening rates were as follows: STD only (138,425; 18%), hepatitis only (59,707; 23%), abortion/ miscarriage only (753; 10%); STD and hepatitis (59,997; 86%), STD and abortion/miscarriage (797; 33%), hepatitis and abortion/miscarriage (13; 54%), and STD, hepatitis, and abortion/miscarriage (269; 93%). Multivariate analyses revealed that women were less likely to be screened than men (OR 0.9, 95% CI 0.8-0.9, $p < 0.001$). Members 18 to 50 years were more likely to be screened than members 14 to 17 (OR 1.2, 95% CI 1.1-1.3, $p < 0.001$), but members 51-64 were less likely to be screened than members 14 to 17 (OR 0.5, 95% CI 0.4-0.5, $p < 0.001$). Members treated in emergency rooms (ER) were less likely to be screened than members seen in other settings (OR 0.86, 95% CI 0.85-0.87, $p < 0.001$).[Citation: Chen JY, Tian H, Dahlin-Lee E, Everhad F, Mayer K. HIV Screening among Privately Insured Members at High Risk of Acquiring HIV Infection. 2008 National Summit on HIV Diagnosis, Prevention and Access to Care. November 19-21, 2008. Crystal City, VA.] The overall 36% screening rate of members was similar to rate reported form 2002 National Health Interview Survey (21%) for HIV screening rate among members with presents with complaint of STD. [Citation: Branson, B. Overview of Routine/expanded HIV Testing in the US. 2008 National Summit on HIV

	Diagnosis, Prevention, and Access to Care.]
27 (2d)	**Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.* **Summary of Evidence supporting exclusion(s):** Members with previously diagnosed HIV are excluded because their HIV status is already known. **Citations for Evidence:** N/A **Data/sample:** N/A **Analytic Method:** N/A **Testing Results:** N/A
28 (2e)	**Risk Adjustment Testing** *Summarize the testing used to determine the need (or no need) for risk adjustment and the statistical performance of the risk adjustment method.* **Data/sample:** N/A **Analytic Method:** N/A **Testing Results:** N/A ►**If outcome or resource use measure not risk adjusted, provide rationale:**
29 (2g)	**Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*) **Data/sample:** N/A **Analytic Method:** N/A **Results:** N/A
30 (2f)	**Provide Measure Results from Testing or Current Use** (select one) **Data/sample:** See boxes 25 and 26 **Methods to identify statistically significant and practically/meaningfully differences in performance:** **Results:**
31 (2h)	**Identification of Disparities** ►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:** N/A ►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale:
	USABILITY
32 (3)	*Current Use Testing completed* *If in use, how widely used (select one)* ► *If "other," please describe:* ☐ *Used in a public reporting initiative, name of initiative:* *Sample report attached* ☐ *OR Web page URL:*
33	**Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential*

(3a)	*users for public reporting and quality improvement*) **Data/sample:** Data are reported as rates and denominator sizes. It was felt that no interpretability testing was needed. Based upon numerous interactions with health plans, performance based on denominator and rate are easily interpreted, as long as the populations captured in numerator, denominator and denominator exclusion are made explicit. **Methods:** N/A **Results:** N/A
34 (3b, 3c)	**Relation to other NQF-endorsed™ measures** ►Is this measure similar or related to measure(s) already endorsed by NQF (on the same topic or the same target population)? *Measures can be found at www.qualityforum.org under Core Documents.* *Check all that apply* ☐ Have not looked at other NQF measures ☐ Other measure(s) on same topic ☐ Other measure(s) for same target population ☒ No similar or related measures **Name of similar or related NQF-endorsed™ measure(s):** **Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one) ►If not fully harmonized, provide rationale: **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:**
	FEASIBILITY
35 (4a)	*How are the required data elements generated? Check all that apply* ☐ *Data elements are generated concurrent with and as a byproduct of care processes during care delivery (e.g., blood pressure or other assessment recorded by personnel conducting the assessment)* ☐ *Data elements are generated from a patient survey (e.g., CAHPS)* ☒ *Data elements are generated through coding performed by someone other than the person who obtained the original information (e.g., DRG or ICD-9 coding on claims)* ☐ *Other, Please describe:*
36 (4b)	*Electronic Sources All data elements* ►*If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:* ►*Specify the data elements for the electronic health record: ICD-9 diagnosis codes, ICD-9 Proc Codes, CPT-4 codes, HCPCS codes, UB revenue codes, NDC code, DRG codes*
37 (4c)	*Do the specified exclusions require additional data sources beyond what is required for the other specifications? No* ►*If yes, provide justification:*
38 (4d)	*Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure: This is a administrative claims-based quality indicator with certain potential biases, including coding variation between providers and missing data. Nevertheless, administrative claims data is the widely available and has been used to effectively examine and document patterns of health care utilization, detect opportunities to improve quality of care, estimate incidence of disease, and even assess outcomes of pharmaceutical, radiological, and surgical procedures.* *Describe how could these potential problems be audited: HBI has developed an online tool (currently in use by several health plans), which allows physicians the opportunity to supplement their quality scores through self-report via a secured web site. Via this website, physicians are able to identify specific patients with whom they had an office visit during the measurement period and who reportedly did not have the indicated quality care. Physicians can then review their charts to verify whether in fact the*

	quality care was performed. The physician can then manually enter corrections to the patient record via the website, indicating that the quality care was done. This data is subject to clinical review prior to acceptance. The hybrid quality score (via administrative claims and self report) can be updated on a quarterly basis. *Did you audit for these potential problems during testing? No If yes, provide results:*
39 (4e)	*Testing feasibility Describe what have you learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: Screening tests for chlamydia/gonhorrhea among women are not included in the denominator, as these test are often part of routine gynocological exams and would confound the true HIV screening rate. However, chlamydia and gonhorrhea diagnoses do qualify women for the denominator.*
	CONTACT INFORMATION
40	*Web Page URL for Measure Information Describe where users (implementers) should go for more details on specifications of measures, or assistance in implementing the measure.* *Web page URL: N/A*
41	**Measure Intellectual Property Agreement Owner Point of Contact** **First Name:** Zak **MI:** **Last Name:** Ramadan-Jradi **Credentials (MD, MPH, etc.):** MD, MPH **Organization:** Health Benchmarks® **Street Address:** 21650 Oxnard St., Suite 550 **City:** Woodland Hills **State:** CA **ZIP:** 91367-7806 **Email:** zramadan@us.imshealth.com **Telephone:** 818-676-2820 ext:
42	**Measure Submission Point of Contact** **If different than IP Owner Contact** **First Name:** Karen **MI:** **Last Name:** Hsu **Credentials (MD, MPH, etc.):** MPH, MBA **Organization:** Health Benchmarks® **Street Address:** 21650 Oxnard St., Suite 550 **City:** Woodland Hills **State:** CA **ZIP:** 91367-7806 **Email:** khsu@us.imshealth.com **Telephone:** 541-550-7983 ext:
43	**Measure Developer Point of Contact** **If different than IP Owner Contact** **First Name:** Judy **MI:** Y **Last Name:** Chen **Credentials (MD, MPH, etc.):** MD, MSHS **Organization:** Health Benchmarks® **Street Address:** 21650 Oxnard St., Suite 550 **City:** Woodland Hills **State:** CA **ZIP:** 91367-7806 **Email:** judy.chen@us.imshealth.com **Telephone:** 818-676-2883 ext:
44	**Measure Steward Point of Contact** **If different than IP Owner Contact** *Identifies the organization that will take responsibility for updating the measure and assuring it is consistent with the scientific evidence and current coding schema; the steward of the measure may be different than the developer.* **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:** **Email:** **Telephone:** ext
	ADDITIONAL INFORMATION
45	**Workgroup/Expert Panel involved in measure development** No workgroup or panel used ►If workgroup used, describe the members' role in measure development: ►Provide a list of workgroup/panel members' names and organizations:
46	*Measure Developer/Steward Updates and Ongoing Maintenance* *Year the measure was first released: 2008* *Month and Year of most recent revision: November, 2008* *What is the frequency for review/update of this measure? Yearly* *When is the next scheduled review/update for this measure? September, 2009*
47	**Copyright statement/disclaimers:** © 2008 Health Benchmarks®

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48	**Additional Information:** N/A
49	**I have checked that the submission is complete and any blank fields indicate that no information is provided.** ☒
50	**Date of Submission** (*MM/DD/YY*)**:** 11/21/08

PATIENT & FAMILY ENGAGEMENT

PRIORITY STATEMENT: Engage Patients and Their Families in Managing Their Health and Making Decisions About Their Care

1.1. All providers will routinely solicit and publicly report on their patients' perspectives of care

1.2. All providers will work collaboratively with their patients to assist them in making informed decisions about treatment options consistent with their values and preferences

POPULATION HEALTH

PRIORITY STATEMENT: IMPROVE THE HEALTH OF THE U.S. POPULATION

2.1. The population will be up to date on all high-priority age- and gender-appropriate evidence-based clinical preventive services

2.2. The population will receive recommended evidence-based interventions to improve targeted healthy lifestyle behaviors

2.3. All communities will demonstrate a 10% improvement in their community index of health

2.4. Americans will have all recommended high priority healthy lifestyle behaviors under control

SAFETY

PRIORITY STATEMENT: IMPROVE THE SAFETY OF THE U.S. HEALTH CARE SYSTEM

3.1. All providers will drive all preventable healthcare-associated infections (HAI) to zero

3.2. All providers will drive the incidence of preventable NQF Serious Reportable Events (SRE) to zero

3.3. All hospitals will reduce preventable and premature mortality rates to best-in-class

3.4. All hospitals and their community partners will reduce 30-day mortality rates following hospitalization for select conditions to best-in-class

PALLIATIVE CARE

PRIORITY STATEMENT: GUARANTEE APPROPRIATE AND COMPASSIONATE CARE FOR PATIENTS WITH LIFE-LIMITING ILLNESSES

4.1. All providers will identify, document, and effectively treat physical symptoms (e.g. pain, shortness of breath, constipation, others) at levels acceptable to patients with a life-limiting illness

4.2. All providers will effectively address the psychosocial and spiritual needs of patients with life-limiting illnesses and their families according to their preferences

4.3. All eligible patients will receive high quality palliative care and hospice services

CARE COORDINATION

PRIORITY STATEMENT: ENSURE PATIENTS RECEIVE WELL-COORDINATED CARE ACROSS ALL PROVIDERS, SETTINGS, AND LEVELS OF CARE

5.1. All providers will accurately and completely reconcile medications across the continuum of care (i.e. admission, transfer within and between care providers, discharge, and outpatient appointments) and ensure communication with the next provider of services

5.2. All inpatient and outpatient providers will assess the patient's perspective of the coordination of their care using a validated care coordination survey tool

5.3. All providers will reduce 30-day all-cause readmission rates resulting from poorly coordinated care to best-in-class

5.4. All providers will reduce preventable emergency department (i.e. those that could be avoided with timely access to primary care) visits resulting from poorly coordinated care by 50%

PATIENT-FOCUSED CARE

PRIORITY STATEMENT: GUARANTEE HIGH VALUE CARE ACROSS ACUTE AND CHRONIC EPISODES

6.1. All patients will receive high-value care over the course of their acute or chronic illness

OVERUSE

PRIORITY STATEMENT: ELIMINATE WASTE WHILE ENSURING THE DELIVERY OF APPROPRIATE CARE

7.1. Reduce wasteful and inappropriate care for the top ten targeted areas by 50%