9/7/2016 NQF: Untitled Submission



Print



Project Name

Measure # xxxx

Measure Title Untitled Submission

Last Edit Date 09.07.2016 ‐ 01:44 AM

Last Edit By Mark Tobias

Measure Process New Measure

Status Unassigned Draft

Introduction



Thank you for your interest in submitting a measure to NQF for possible endorsement.

What criteria are used to evaluate measures? Measures are evaluated on standardized criteria: importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and related and competing measures. For your measure to be evaluated against these [measure evaluation criteria](http://nqf.qualityforum.dev.win.dotnet.panth.com/Measuring_Performance/Submitting_Standards.aspx), you must complete the measure submission form.

Why do I have to complete a form? Due to the volume and/or complexity of proposed measures, NQF provides measure information to [committee reviewers in a standardized format to facilitate their evaluation of whether the measure meets NQF's measure evaluation](http://nqf.qualityforum.dev.win.dotnet.panth.com/Measuring_Performance/Submitting_Standards.aspx) [criteria. This form allows the measure steward to present information demonstrating that the proposed measure meets NQF's criteria.](http://nqf.qualityforum.dev.win.dotnet.panth.com/Measuring_Performance/Submitting_Standards.aspx)

What is on the form? The information requested in this form is directly related to NQF's [measure evaluation criteria](http://nqf.qualityforum.dev.win.dotnet.panth.com/Measuring_Performance/Submitting_Standards.aspx).

Can't I just submit our files for consideration? No. Measures must be submitted through the online form to be considered. Requested information should be entered directly into this form and the required attachments for evidence and measure testing.

Can I submit additional details and materials? Additional materials will be considered only as supplemental. Do NOT rely on material provided in an appendix to provide measure specifications or to demonstrate meeting the criteria. The core information needed to evaluate the measure should be provided in the appropriate submission form fields and required attachments. Please contact the designated project staff regarding questions about submitting supplemental materials.

What do I do first? When you first start a new submission by selecting the type of measure form (e.g., quality or resource use measure), you will be directed to the "NQF Conditions" tab, which lists the conditions that must be met before your proposed measures may be considered and evaluated for suitability as NQF‐endorsed voluntary consensus standards. You are asked to acknowledge reading and accepting the conditions.

Can I come back later to complete a submission once I have started? Yes. You can return to your submission at your convenience to complete the form until the designated deadline for the specific project. To save and return, simply click on the save‐draft option anytime during the submission process. When you want to continue, please login to the National Quality Forum website, go to your Dashboard, and click on submission.

Can I make changes to a form once I have submitted it? No. Once you submit your measure, you will NOT be able to return to this submission form to make further revisions. You will need to contact project staff.

What if I need additional help? Please contact the project staff identified in the call for measures if you have questions regarding the information requested or submitting supplemental materials.

Please email us at [web‐help@qualityforum.org](mailto:web-help@qualityforum.org?subject=Measure%20Submission%20Form) if you experience technical difficulties using the online submission form.

Thank you for your interest in submitting measures to NQF.



NQF Conditions

Conditions that must be met for consideration by NQF

Is this a measure (or updated version of a measure previously submitted to NQF and given an NQF#?

 Yes

 No

If the measure has a related eMeasure please indicate the NQF# of both measures.

Several conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards. If any of the conditions are not met, the measure will not be accepted for consideration.

1. The measure is in the public domain or a Measure Steward Agreement is signed. (All non‐government organizations must sign a Measure Steward Agreement even if measures are made publicly and freely available.)
2. The measure owner/steward verifies there is an identified responsible entity and a process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every three years.
3. The intended use of the measure includes both accountability applications (including public reporting) and performance improvement to achieve high‐quality, efficient healthcare.
4. The measure is fully specified and tested for reliability and validity.
5. The measure developer/steward attests that harmonization with related measures and issues with competing measures have been considered and addressed, as appropriate.
6. The requested measure submission information is complete and responsive to the questions so that all the information needed to evaluate all criteria is provided.

Do you agree to these conditions?

 I have read and accept the conditions as specified above \*



Specifications



Descriptive Information

De.1. Measure Type *(Patient‐reported outcomes include HRQoL/functional status, symptom/burden, experience* *with care, health‐related behavior.)*\*

Process

[De.2. Measure Title *‐ Measure titles should be concise yet convey who and what is being measured (see* What](http://nqf.qualityforum.dev.win.dotnet.panth.com/docs/what_good_looks_like.aspx) [Good Looks Like*)*\*](http://nqf.qualityforum.dev.win.dotnet.panth.com/docs/what_good_looks_like.aspx)

HIV Medical Visit Frequency

De.3. Brief description of measure (*including type of score, measure focus, target population, timeframe, e.g.,* *Percentage of adult patients aged 18‐75 years receiving one or more HbA1c tests per year*)

Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period within 24 months with a minimum of 60 days between medical visits.

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?



Measure Specifications

S.1. Measure‐specific Web Page *(Provide a URL link to a web page specific for this measure that contains current* *detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)*

There is no measure-specific web page for the electronic version of this measure. The HQMF specifications and associated Measure Authoring Tool artifacts are included as an attachment to this submission (see answer to question S.2a below). The value sets used in this measure are published in the Value Set Authority Center (https://vsac.nlm.nih.gov).

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) ‐ if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain‐language description of the specifications)

● This is an eMeasure

 This is not an eMeasure

S.2b. Data Dictionary, Code Table, or Value Sets *(and risk model codes and coefficients when applicable) must* *be attached. (Excel or csv file in the suggested format preferred ‐ if not, contact staff. Provide descriptors for any codes. Use one file with multiple worksheets as needed.)*

● Available in attached Excel or csv file

 No data dictionary/code table – all information provided in the submission form

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1‐2 and S4‐22 and explain reasons for the changes in S3.2.

 Yes

 No

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

Not applicable

S.4. Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the* *target population, i.e., cases from the target population with the target process, condition, event, or outcome). DO NOT include the rationale for the measure.*

*IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk‐adjusted outcome should be described in the calculation algorithm (S.14).*

Patients who had at least one medical visit in each 6-month of a consecutive consecutive 24 month period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period.

S.5. 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, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

*IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk‐ adjusted outcome should be described in the calculation algorithm (S.14).*

HIV medical visits are represented by a QDM variable that is comprised of the below seven different encounter type QDM elements:

* Encounter, Performed: Face-to-Face Interaction using Face-to-Face Interaction Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1048)
* Encounter, Performed: Office Visit using Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)
* Encounter, Performed: Outpatient Consultation using Outpatient Consultation Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1008)
* Encounter, Performed: Preventive Care - Established Office Visit, 0 to 17 using Preventive Care - Established Office Visit, 0 to 17 Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1024)
* Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up using Preventive Care Services - Established Office Visit, 18 and Up Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1025)
* Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up using Preventive Care Services-Initial Office Visit, 18 and Up Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1023)
* Encounter, Performed: Preventive Care- Initial Office Visit, 0 to 17 using Preventive Care- Initial Office Visit, 0 to 17 Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1022)

S.6. Denominator Statement *(Brief, narrative description of the target population being measured)*

*IF an OUTCOME MEASURE, state the target population for the outcome. Calculation of the risk‐adjusted outcome should be described in the calculation algorithm (S.14).*

Patients, regardless of age, diagnosed with HIV during the first 3 months of the year preceding the measurement period or prior to the measurement period with at least one medical visit in the first 6 months of the year preceding the measurement period.

The target population for this measure is all people living with HIV.

S.7. Denominator Details *(All information required to identify and calculate the target population/denominator* *such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

*IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk‐adjusted outcome should be described in the calculation algorithm (S.14).*

The patient’s HIV diagnosis is represented by the QDM element "Diagnosis: HIV" using "HIV Grouping Value Set (2.16.840.1.113883.3.464.1003.120.12.1003)". The patient’s medical visits are represented by the following QDM elements:

* Encounter, Performed: Face-to-Face Interaction using Face-to-Face Interaction Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1048)
* Encounter, Performed: Office Visit using Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)
* Encounter, Performed: Outpatient Consultation using Outpatient Consultation Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1008)
* Encounter, Performed: Preventive Care - Established Office Visit, 0 to 17 using Preventive Care - Established Office Visit, 0 to 17 Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1024)
* Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up using Preventive Care Services - Established Office Visit, 18 and Up Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1025)
* Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up using Preventive Care Services-Initial Office Visit, 18 and Up Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1023)
* Encounter, Performed: Preventive Care- Initial Office Visit, 0 to 17 using Preventive Care- Initial Office Visit, 0 to 17 Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1022)

The target population is identified by selecting patients based on their diagnosis with HIV.

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

Patients who died at any time during the measurement period or the 12 months preceding the measurement period.

S.9. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the* *denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

Denominator exclusions are a subset of the denominator that should not be considered for inclusion in the numerator. This measure denominator exclusion excludes patients who died at any time during the measurement period or the 12 months preceding the measurement period.

Patient death is identified by using the QDM datatype of “Patient Characteristic Expired.” In alignment with the CMS/ONC Electronic Clinical Quality Measure Logic and Implementation Guidance Version 1.12 and the Quality Data Model, Version 4.2 and Version 4.3, the “Patient Characteristic Expired” data element is fixed to SNOMED-CT code 41909909 (Dead) and therefore cannot be further qualified with a value set.

S.10. Stratification Information *(Provide all information required to stratify the measure results, if necessary,* *including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk‐model covariates and coefficients for the clinically‐adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)*

Not applicable.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

Not applicable.

S.12. Type of score: Proportion

S.13. 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 is associated with a higher score.

S.14. Calculation Algorithm/Measure Logic *(Diagram or 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; time period of data, aggregating data; risk adjustment; etc.)*

1. Identify patients who meet the initial population criteria as defined by eCQM logic;

2. Identify and count subset of the initial population that meet denominator criteria as defined by eCQM logic;

3. Identify and count subset of patients in the denominator that meet numerator criteria as defined by eCQM logic.

4. Calculate the performance measure rate: by dividing the number of patients in the numerator population by the number of patients in the denominator population.

Note: the eCQM logic criteria for each population is defined in a computable format in the eCQM specifications provided as an attachment to this submission.

S.15. Sampling *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on* *minimum sample size.)*

IF a PRO‐based performance measure (PRO‐PM), identify whether (and how) proxy responses are allowed.

This measure does not sample.

S.16. Survey/Patient‐reported data *(If measure is based on a survey or instrument, provide instructions for data* *collection and guidance on minimum response rate.)*

IF a PRO‐PM, specify calculation of response rates to be reported with performance measure results.

This measure is not based on a survey or instrument.

S.17. Data Source *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).* *If other, please describe in S.18.*

 Claims (Other)  Management Data

 EHRs Hybrid  Pharmacy

 Non‐Medical Data  Registry

 Claims (Only)  Paper Records

☒ Electronic Health Record (Only)  Patient Reported Data

 Imaging‐Diagnostic  Other

 Laboratory

 Provider Tool

S.18. Data Source or Collection Instrument *(Identify the specific data source/data collection instrument e.g.* *name of database, clinical registry, collection instrument, etc., and describe how data is collected.)*

IF a PRO‐PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

Data is obtained from structured data fields in electronic health records.

S.19. Data Source or Collection Instrument *(available at measure‐specific Web page URL identified in S.1 OR in* *attached appendix)*

 Available at measure‐specific web page URL identified in S.1

 Available in attached appendix at A.1

● No data collection instrument provided

S.20. Level of Analysis *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)*

 Other  Integrated Delivery System

 Clinician : Individual  Population : Community, County or City

 Clinician : Group/Practice  Population : Regional and State

☒ Facility

 Health Plan

S.21. Care Setting *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*

 Emergency Department  Emergency Medical Services/Ambulance

 Birthing Center  Urgent Care ‐ Ambulatory

 No Applicable Care Setting  Home Health

 Ambulatory Surgery Center  Hospice

 Nursing Home / SNF  Hospital : Hospital

☒ Clinician Office/Clinic  Hospital : Critical Care

 Inpatient Rehabilitation Facility  Hospital : Acute Care Facility

 Behavioral Health : Inpatient  Imaging Facility

 Behavioral Health : Outpatient  Laboratory

 Long Term Acute Care  Pharmacy

 Outpatient Rehabilitation  Other

 Dialysis Facility

S.22. COMPOSITE Performance Measure ‐ Additional Specifications *(Use this section as needed for aggregation* *and weighting rules,or calculation of individual performance measures if not individually endorsed.)*

 This is not a composite measure.



Importance

Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three sub‐criteria must be met to pass this criterion. See guidance on evidence.

Evidence ([Measure evaluation criterion 1a](http://nqf.qualityforum.dev.win.dotnet.panth.com/#1a))

1a. Attach evidence submission form ([Click here to download Evidence Submission Form Template](http://nqf.qualityforum.dev.win.dotnet.panth.com/docs/NQF_evidence_attachment_FINAL_2016.aspx))

1a.1. For maintenance of endorsement:

Is there new evidence about the measure since the last update/submission?

Please update any changes in the evidence attachment in red. Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. If there is no new evidence, no updating of the evidence information is needed.

 Yes

 No

Performance Gap ‐ Opportunity for Improvement ([Measure evaluation criterion 1b](http://nqf.qualityforum.dev.win.dotnet.panth.com/#1b))

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

IF a PRO‐PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health‐related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

IF a COMPOSITE (e.g., combination of component measure scores, all‐or‐none, any‐or‐none), SKIP this question and provide rationale for composite in question 1c.3 on the composite tab.

1b.2. Provide performance scores on the measure as specified ( current and over time ) at the specified level of analysis. (This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include). This information also will be used to address the sub‐criterion on improvement (4b) under Usability and Use.

There is no data currently available for the electronic version of the measure.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement. Include citations.

Below are the performance scores for the chart-abstracted version of the measure.

We utilized the multisite HIV Research Network (HIVRN), a consortium of community and academic HIV providers care sites, linked by a centralized Data Coordinating Center (DCC). The HIVRN has 11 participating treatment sites (10 adolescent/adult sites and 1 pediatric site). The sites are representative of both academic and community-based HIV care; of the 4 major geographic divisions of the U.S. of the demographic diversity of HIV infection across the U.S. and of the insurance status and coverage types typical of the population in care. The measurement periods included calendar years 2007-2008, 2008-2009, 2009-2010, 2014-2015. More information can be found on the HIVRN website regarding a site location, additional data, and more.

All of the patients in the HIVRN dataset have a diagnosis of HIV. Patients were included, regardless of age, in each measurement period if they had a medical visit in the first 6 months of the measurement period and did not die during the measurement period. The following lists the number of patients included for each measurement period. Due to resource constraints, 2011-2013 were not included in the analysis to allow for inclusion of the most recent measurement period for this measure (2014-2016) with limited analysis available.

|  |  |
| --- | --- |
| Year | Number of patients included |
| 2007-2008 | 15,790 |
| 2008-2009 | 16,881 |
| 2009-2010 | 17,687 |
| 2014-2015 | 15,049 |

Provider-level medical visit frequency performance scores, 2014-2015

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Provider Site | Total N | Percent of patients with a medical visit in each six month segment of the measurement period | Lower confidence interval | Upper confidence interval |
| A | 399 | 55.13 | 50.22 | 59.95 |
| B | 1910 | 63.24 | 61.05 | 65.38 |
| C | 1425 | 68.21 | 65.74 | 70.57 |
| D | 1490 | 68.45 | 66.05 | 70.76 |
| E | 1276 | 68.8 | 66.21 | 71.92 |
| F | 4549 | 70.93 | 69.6 | 72.24 |
| G | 630 | 78.88 | 75.52 | 81.37 |
| H | 745 | 79.19 | 76.12 | 81.89 |
| I | 1582 | 79.45 | 77.39 | 81.95 |
| J | 452 | 82.74 | 78.97 | 85.95 |
| K | 591 | 83.76 | 80.55 | 86.51 |

Summary statistics for proportion of 2014-2015 patients meeting the numerator criteria across providers.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 2007-2008 | 2008-2009 | 2009-2010 | 2014-2015 |
| Minimum | 47.1% | 42.5% | 50.1% | 55.1% |
| Maximum | 86.1% | 83.1% | 82.8% | 83.8% |
| Mean | 66.7% | 67.73% | 68.9% | 72.6% |
| 25th percentile | 59.7% | 59.9% | 63.4% | 68.2% |
| 50th percentile | 70.6% | 66.2% | 67.7% | 70.9% |
| 75th percentile | 78.2% | 75.5% | 74.6% | 79.5% |

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub‐populations. This information also will be used to address the sub‐criterion on improvement (4b) under Usability and Use.

There is no data currently available for the electronic version of the measure.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement.

Include citations. Not necessary if performance data provided in 1b.4.

Client-level performance scores for medical visit frequency for 2007-2014 are presented below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 2007-2008 | 2008-2009 | 2009-2010 | 2014-2015 |
| Race/Ethnicity: |  |  |  |  |
| African American/Caribbean | 64.8% | 67.0% | 67.5% | 72.7% |
| White, not Hispanic | 67.3% | 65.8% | 67.9% | 75.2% |
| Hispanic | 71.2% | 72.9% | 73.9% | 67.9% |
| Other | 73.0% | 68.5% | 68.8% | 66.2% |
| Gender: |  |  |  |  |
| Male | 66.2% | 67.5% | 68.5% | 69.9% |
| Female | 68.2% | 68.4% | 69.8% | 76.0% |
| Transgender | 62.4% | 65.8% | 72.9% | 66.7% |
| Age: |  |  |  |  |
| <18 | 87.2% | 87.3% | 87.8% | 88.7% |
| 18-29 | 53.3% | 54.2% | 56.8% | 62.9% |
| 30-49 | 64.6% | 66.0% | 66.4% | 67.5% |
| 50+ | 73.7% | 73.7% | 75.9% | 76.1% |
| HIV Risk: |  |  |  |  |
| IV Drug Use | 64.6% | 67.1% | 67.6% | 74.3% |
| Men Having Sex with Men | 66.8% | 67.7% | 69.4% | 67.9% |
| Heterosexual Contact | 67.0% | 67.4% | 68.7% | 75.2% |
| Vertical | 87.2% | 87.0% | 84.4% | 67.9% |
| Blood | 70.7% | 68.3% | 67.5% | 75.5% |
| Other/Unknown | 51.3% | 57.0% | 59.9% | 67.1% |
| Insurance: |  |  |  |  |
| Private | 76.9% | 76.5% | 74.6% | 64.6% |
| Medicaid | 78.8% | 78.7% | 80.9% | 72.2% |
| Medicare | 81.4% | 81.2% | 82.3% | 75.4% |
| Dual (Medicare and Medicaid) | 87.2% | 87.0% | 81.0% | 76.7% |
| Uninsured | 62.1% | 56.9% | 62.6% | 69.4% |
| Ryan White | 74.1% | 77.3% | 77.4% | 68.7% |
| Other/Unknown | 66.2% | 64.7% | 66.3% | 73.5% |
| Site Type: |  |  |  |  |
| Hospital-based | 66.4% | 68.1% | 68.9% | 69.4% |
| Community-based | 67.9% | 66.6% | 69.0% | 79.3% |



Scientific Acceptability



Testing Attachment

2. Attach measure testing form (Click to here to download the [Measure Testing Form Template](http://nqf.qualityforum.dev.win.dotnet.panth.com/docs/NQF_testing_attachment_FINAL_2016.aspx) OR the Composite Measure Testing Form.)

2.1. For maintenance of endorsement:

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

 Yes

 No

2.2. For maintenance of endorsement:

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

 Yes

 No

2.3. For maintenance of endorsement:

Risk adjustment: For outcome, resource use, cost, and some process measures, risk‐adjustment that includes SDS factors is no longer prohibited during the SDS Trial Period (2015‐2016). Please update sections 1.8, 2a2, 2b2, 2b4, and 2b6 in the Testing attachment and S.14 and S.15 in the online submission form in accordance with the requirements for the SDS Trial Period . NOTE: These sections must be updated even if SDS factors are not included in the risk‐adjustment strategy. If yes, and your testing attachment does not have the additional questions for the SDS Trial please add these questions to your testing attachment:

What were the patient‐level sociodemographic (SDS) variables that were available and analyzed in the data or

sample used? For example, patient‐reported data (e.g., income, education, language), proxy variables when SDS data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate).

Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or sociodemographic factors) used in the statistical risk model or for stratification by risk (e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of p<0.10; correlation of x or higher; patient factors should be present at the start of care)

What were the statistical results of the analyses used to select risk factors?

Describe the analyses and interpretation resulting in the decision to select SDS factors (e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between‐unit effects and within‐unit effects)

 Yes ‐Updated information required during the SDS Trial Period is included.  No ‐ This measure is not risk‐adjusted.



Feasibility



Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance

measurement.

Data Elements Generated as Byproduct of Care Processes ([Measure evaluation criterion 3a](http://nqf.qualityforum.dev.win.dotnet.panth.com/#3a))

3a.1. How are the data elements needed to compute measure scores generated? (Check all that apply)

Data used in the measure are:

☒ Generated "or collected" by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, "depression score")

 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)

 Other



Electronic Sources ([Measure evaluation criterion 3b](http://nqf.qualityforum.dev.win.dotnet.panth.com/#3b))

3b.1. To what extent are the specified data elements available electronically in defined fields ( *i.e., data* *elements that are needed to compute the performance measure score are in defined, computer‐readable fields*)Update this field for maintenance of endorsement.

● ALL data elements are in defined fields in electronic health records (EHRs)

 ALL data elements are in defined fields in electronic claim

 ALL data elements are in defined fields in electronic clinical data (e.g., clinical registry, nursing home MDS, home health OASIS)

 ALL data elements are in defined fields in a combination of electronic sources

 Some data elements are in defined fields in electronic sources

 No data elements are in defined fields in electronic sources  Patient/family reported information (may be electronic or paper)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near‐term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

Not applicable.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure‐specific URL. Please also complete and attach the NQF Feasibility Score Card.



Data Collection Strategy ([Measure evaluation criterion 3c](http://nqf.qualityforum.dev.win.dotnet.panth.com/#3c))

3c.1. Required for maintenance of endorsement. Describe difficulties (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.

IF a PRO‐PM, consider implications for both individuals providing PRO data (patients, service recipients, respondents) and those whose performance is being measured.

Not applicable.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm)?

The measure specifications contain limited proprietary codes for convenience. Users of CPT(R) should obtain all necessary licenses from the owners of these code sets.

The use of SNOMED Clinical Terms(R) requires a Unified Medical Language System (UMLS) license. These licenses are freely available, from the National Library of Medicine.



Usability and Use



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.

*NQF‐endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.*

4.1. Current and Planned Use *(check all the current and planned uses; for any current uses that are checked,* *provide a program name and URL for the specific program)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Intended Use | Specific | Current | For current use, provide Program Name and URL |  |
|  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  | |
|  |  | Plan for |  | Use |  |
|  |  | Use |  |  |  |
|  |  |  |  |  |  |
|  | a. Public Reporting |  |  |  |  |
|  |  | X |  |  |  |
|  | b. Public Health/Disease Surveillance | X |  |  |  |
|  |  |  |  |  |  |
|  | c. Payment Program | X |  |  |  |
|  |  |  |  |  |  |
|  | d. Regulatory and Accreditation Programs |  |  |  |  |
|  |  |  |  |  |  |
|  | e. Professional Certification or Recognition |  |  |  |  |
|  | Program |  |  |  |  |
|  |  |  |  |  |  |
|  | f. Quality Improvement with Benchmarking |  |  |  |  |
|  | (external benchmarking to multiple | X |  |  |  |
|  | organizations) |  |  |  |  |
|  |  |  |  |  |  |
|  | g. Quality Improvement (Internal to the specific |  |  |  |  |
|  | organization) | X |  |  |  |
|  |  |  |  |  |  |



h. Not in use

i. Use Unknown

Accountability/Transparency ([measure evaluation criterion 4a](http://nqf.qualityforum.dev.win.dotnet.panth.com/#4a))

4a.1. For each CURRENT use, checked above (update for maintenance of endorsement), provide:

Name of program and sponsor Purpose; Geographic area and number and percentage of accountable entities and patients included Level of measurement and setting

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g.*, Do policies or actions of the* *developer/steward or accountable entities restrict access to performance results or impede implementation?*) N/A

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes ‐‐ any accountability application within 3 years and publicly reported within 6 years of initial endorsement. N/A

Improvement ([measure evaluation criterion 4b](http://nqf.qualityforum.dev.win.dotnet.panth.com/#4b))

4b. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high‐quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

4b. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high‐quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

Medical visit frequency is a measurement of retention in HIV medical care and specifically geared towards longer term retention. Performance has been improving over time. Based on the HIVRN data, representing over 15,000 patients annually, performance has increased from 66.7% in 2007-2008 to 72.6% in 2014-2015. Many, but not all of the demographic groups and subpopulations have seen improvements in the medical visit frequency measure.

Unexpected findings ([measure evaluation criterion 4c](http://nqf.qualityforum.dev.win.dotnet.panth.com/#4c))

4c.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

The adoption and use of this measure has continued to spread since the initial development of this measure. This measure has been adopted by Centers for Medicare and Medicaid measurement programs, Department of Health and Human Service Secretary as a one of the core HIV indicators, countless outpatient/ambulatory care settings, and health departments. National learning collaborates have used this measure to focus the improvement efforts of grant recipients and subrecipients. Additionally, retention is the final and goal of the five stages of the HIV care continuum.

4c.2. Please explain any unexpected benefits from implementation of this measure.

N/A

4d1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

This measure has been used in national quality improvement campaigns, learning collaborative, and learning exchange. Participants commit to using this measure, reporting performance scores and disparity stratifications, and developing quality improvement projects based on this measure. Performance scores and disparity stratification data are shared with participants in order to benchmark performance.

HRSA is releasing a quality module where grant recipients can voluntarily report numerator, denominator, and performance scores for a portfolio of measures. Grant recipients will be able to benchmark their performance based on a number of patient demographic and organizational factors. This measure will be included in the measure portfolio.

4d1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

For the national quality improvement campaign, data were collected and aggregated from participants across the United States every other month. Reports were developed and released based on a number of organizational factors (type of funding, location, etc.). Reports included data tables and spark lines and available on a public website and presented in public, national webinars. Similar efforts were employed for the learning collaborative and learning exchange.

4d2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Antidotal feedback has been received regarding the use of performance measures, collection of data, and dissemination of reports from participating Ryan White HIV/AIDS Program grant recipients. All of the feedback was positive, supportive, and encouraged further stratification, dissemination methods, and graphical presentations. Feedback was incorporated in dissemination efforts based on feasibility and resource availability.

4d2.2. Summarize the feedback obtained from those being measured.

See 4d2.2

4d2.3. Summarize the feedback obtained from other users.

Antidotal feedback encouraged continual alignment of measure details (e.g. numerator, denominator, exclusions, etc.) across performance measures and measure programs in order to reduce burden.

4d.3. Describe how the feedback described in 4d.2 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not

During the initial development of the measure, formal feedback was gathered. The measures were modified during the development phase and have not been modified since. A concerted effort was made to develop a measure that would likely stand the test of time from a scientific, clinical, and patient perspective. On an annual basis, the measure is review for clinical relevance, change in scientific acceptability, and consistency with guidelines. This measure has not been modified as a result of the annual reviews. Additionally, this measure is used by a number of measurement programs and strategies. Each of those programs require a separate annual review. No modifications have been made for those programs.

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.

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.

Relation to Other NQF‐endorsed® Measures ([Measure evaluation criterion 5](http://nqf.qualityforum.dev.win.dotnet.panth.com/#5))

5. Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures. (Can search and select measures.)

0405 HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis

0409 HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis

2080 Gap in HIV Medical Visits

2082 HIV viral suppression

2083 Prescription of HIV Antiretroviral Therapy

3211 Prescription of HIV Antiretroviral Therapy

3210 HIV viral suppression

3010 HIV Medical Visit Frequency

Harmonization of Related Measures ([Measure evaluation criterion 5a](http://nqf.qualityforum.dev.win.dotnet.panth.com/#5a))

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF‐endorsed measure(s):Are the measure specifications harmonized to the extent possible?

Yes

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

Competing Measure(s) ([Measure evaluation criterion 5b](http://nqf.qualityforum.dev.win.dotnet.panth.com/#5b))

5b.1. If this measure conceptually addresses 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.)

This measure does not have a competing measure.