



## Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

### Brief Measure Information

**NQF #:** 1999

**Corresponding Measures:**

**De.2. Measure Title:** Late HIV diagnosis

**Co.1.1. Measure Steward:** Centers for Disease Control and Prevention

**De.3. Brief Description of Measure:** Percentage of persons 13 years and older diagnosed with Stage 3 HIV infection (AIDS) within 3 months of a diagnosis of HIV infection.

**1b.1. Developer Rationale:** This measure provides a means of monitoring the extent to which HIV-infected persons who were unaware of their HIV infection are being tested and diagnosed. A result of the use of this measure could be an increase in early HIV testing. Increased testing for HIV and diagnosis of HIV infection will result in decreased transmission of HIV and better clinical prognosis for infected persons.

**S.4. Numerator Statement:** Persons in denominator statement with a diagnosis of Stage 3 HIV infection (AIDS) within 3 months of diagnosis of HIV infection

**S.7. Denominator Statement:** Persons age 13 years and older diagnosed with HIV during specified calendar year.

**S.10. Denominator Exclusions:** Persons with month of diagnosis missing are excluded (<0.05%)

**De.1. Measure Type:** Outcome

**S.23. Data Source:** Other

**S.26. Level of Analysis:** Population : Regional and State

**IF Endorsement Maintenance – Original Endorsement Date:** Oct 19, 2012 **Most Recent Endorsement Date:** Oct 19, 2012

**IF this measure is included in a composite, NQF Composite#/title:**

**IF this measure is paired/grouped, NQF#/title:**

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

### 1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.**

**1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form**

#### 1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

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

This measure provides a means of monitoring the extent to which HIV-infected persons who were unaware of their HIV infection are being tested and diagnosed. A result of the use of this measure could be an increase in early HIV testing. Increased testing for HIV and diagnosis of HIV infection will result in decreased transmission of HIV and better clinical prognosis for infected persons.

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. 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 included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.**

CDC is transitioning from a measure that examined Stage 3 HIV infection (AIDS) diagnosis within 12 months of diagnosis of HIV infection to Stage 3 HIV infection (AIDS) diagnosis within 3 months of diagnosis of HIV infection. The majority of persons (>80%) diagnosed within 12 months of HIV infection were diagnosed within 3 months. Among persons who had a diagnosis of HIV in 2009, 32% had a diagnosis of Stage 3 HIV infection (AIDS) within 12 months.

**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.**

The most recent published data on diagnosis of Stage 3 HIV infection (AIDS) within 3 months of a diagnosis of HIV infection are for 2005-2007 and are posted at the following link:

[http://www.cdc.gov/hiv/surveillance/resources/reports/2010supp\\_vol16no1/index.htm](http://www.cdc.gov/hiv/surveillance/resources/reports/2010supp_vol16no1/index.htm). Data for 2010 will be published this summer, but are not currently available for release.

In the absence of current data on proportion of persons diagnosed with HIV infection within 3 months of Stage 3 HIV (AIDS), it is important to note that almost 85% of persons diagnosed with Stage 3 HIV infection (AIDS) within 12 months of a diagnosis of HIV infection were in fact diagnosed within 3 months of their HIV diagnosis. Overall, 29.9% of persons diagnosed with HIV in 2005-2007 were diagnosed with AIDS within 3 months per above mentioned report and 36% of persons diagnosed with HIV in 2006 were diagnosed with Stage 3 HIV infection (AIDS) within 12 months (<http://www.cdc.gov/hiv/surveillance/resources/reports/2006report/> -- see Table 2). For both measures, the proportion diagnosed late increased with age, and was highest for persons with "other" risk (includes risk factor not reported or not identified) and lowest among men who have sex with men. For 2009 data see: <http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/index.htm>, Table 10a.

The proportion of persons diagnosed with Stage 3 HIV infection (AIDS) within 12 months of HIV diagnosis has declined from 36% in 2006 to 32% in 2009, thus the proportion diagnosed with Stage 3 HIV infection (AIDS) within 3 months of HIV diagnosis will likely be 3-4 percentage points lower in 2010 than the 29.9% reported in 2005-2007.

**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 endorsement maintenance. 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 subcriterion on improvement (4b.1) under Usability and Use.**

Current data on persons diagnosed with stage 3 HIV infection (AIDS) within 3 months of a diagnosis of HIV infection by age or transmission category are pending publication (summer 2012). Because the great majority of persons diagnosed with Stage 3 HIV infection within 12 months of HIV diagnosis were in fact diagnosed within 3 months of HIV diagnosis, available data on proportion diagnosed with Stage 3 HIV infection (AIDS) within 12 months of HIV diagnosis are a good proxy. The percent of Stage 3 HIV infection (AIDS) diagnoses that are made within 12 months of diagnosis varies by transmission category (e.g. 31% for male-male sexual contact and 45% for male injection drug users), increases with age (e.g. 17% for persons 20-24 and 46% for persons 55-59), and is higher for Hispanics than for whites and Blacks (37% vs 32 and 31% respectively) (<http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/index.htm>, Table 10a).

**1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.**

For data on proportion diagnosed with Stage 3 HIV infection (AIDS) within 12 months of HIV diagnosis, see: CDC HIV Surveillance Report, vol 22, 2010

(<http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/index.htm> -- see Table 10a)

Data from 2005-2007 on proportion diagnosed with Stage 3 HIV infection within 3 months of HIV diagnosis by age and transmission group are available at: [http://www.cdc.gov/hiv/surveillance/resources/reports/2010supp\\_vol16no1/index.htm](http://www.cdc.gov/hiv/surveillance/resources/reports/2010supp_vol16no1/index.htm)

**1c. High Priority (previously referred to as High Impact)**

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

**1c.1. Demonstrated high priority aspect of healthcare**

High resource use, Severity of illness

**1c.2. If Other:**

**1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.**

**List citations in 1c.4.**

Human immunodeficiency virus (HIV) is a communicable infection that leads to a progressive disease with a long asymptomatic period. Approximately 50,000 persons in the United States are newly infected with HIV each year. Without treatment, most persons develop acquired immunodeficiency syndrome (AIDS) within 10 years of HIV infection. Antiretroviral therapy delays this progression and increases the length of survival, but is most effective when initiated during the asymptomatic phase. CDC estimates that approximately 20% of the 1.1 million adults and adolescents living with HIV infection in the United States are unaware of their infection. Persons with late diagnosis of HIV infection have missed opportunities for treatment during the asymptomatic period and for prevention of transmission to others; they also have a shortened life expectancy. HIV testing identifies infected persons, which enables them to seek medical care that can improve the quality and length of their lives and reduce risk for HIV transmission.

**1c.4. Citations for data demonstrating high priority provided in 1a.3**

Impact of knowledge of serostatus on risk behavior and clinical impact of treatment are both reviewed in "Screening for HIV: A review of the evidence for the U.S. Preventive Services Task Force" (Chou R, Hoyt Huffman L, Fu R et al. Ann Int Med 2005;143:55-73.) Based on this review, the USPSTF rated testing of adolescents and adults at increased risk for HIV infection as "A" and testing of adolescents and adults who are not at increased risk for infection "C".

The impact of treatment on transmission was not considered at the time of that review. Supporting studies include one randomized controlled trial (Cohen et al) and 6 observational studies:

Cohen M, Chen YK, McCauley M, et al. Prevention of HIV-1 Infection with Early Antiretroviral Therapy  
NEJM 2011;365:493-505

Bunnell R, Ekwaru JP, Solberg P, et al. Changes in sexual behavior and risk of HIV transmission after antiretroviral therapy and prevention interventions in rural Uganda. AIDS 2006;20:85-92.

Donnell D, Baeten JM, Kiari J, et al. Heterosexual HIV-1 transmission after initiation of antiretroviral therapy: a prospective cohort analysis. Lancet 2010;375:2092-8.

Del Romero J, Castilla J, Hernando V, Rodriguez C, Garcia S. Combined antiretroviral treatment and heterosexual transmission of HIV-1: cross sectional and prospective cohort study. BMJ 2010;340:c2205.

Reynolds SJ, Makumbi F, Nakigozi G, et al. HIV-1 transmission among HIV-1 discordant couples before and after the introduction of antiretroviral therapy. AIDS 2011;25:473-7.

Das M, Chu PL, Santos GM, et al. Decreases in community viral load are accompanied by reductions in new HIV infections in San Francisco. PLoS ONE 2010; 5(6):e11068.

Montaner JS, Lima VD, Barrios R, et al. Association of highly active antiretroviral therapy coverage, population viral load, and yearly new HIV diagnoses in British Columbia, Canada: a population based study. Lancet 2010;376:532-9.

**1c.5. 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.)**

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

**2a.1. Specifications** The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

**De.5. Subject/Topic Area** (check all the areas that apply):

Infectious Diseases (ID) : HIV/AIDS

**De.6. Non-Condition Specific** (check all the areas that apply):

Screening

**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.)

**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)

**Attachment:**

**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)

**Attachment:**

**S.3. For endorsement maintenance**, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

**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)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Persons in denominator statement with a diagnosis of Stage 3 HIV infection (AIDS) within 3 months of diagnosis of HIV infection

**S.5. Time Period for Data** (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

Persons diagnosed with HIV during specified calendar year and with Stage 3 HIV infection (AIDS) within the subsequent 3 month period.

**S.6. 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, 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.

Information is obtained from the National HIV surveillance System. To allow for delays in reporting of HIV and of AIDS diagnoses, cases reported through the end of calendar year following the diagnosis year are included. In addition, standard adjustment for reporting delay is performed. (Song R, Hall HI, Frey R. Uncertainties associated with incidence estimates of HIV/AIDS diagnoses adjusted for reporting delay and risk redistribution. Stat med 2005;24:453-464)

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**S.7. Denominator Statement** (Brief, narrative description of the target population being measured)

Persons age 13 years and older diagnosed with HIV during specified calendar year.

**S.8. Target Population Category** (Check all the populations for which the measure is specified and tested if any):

Elderly

**S.9. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, 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)

Information is obtained from the National HIV surveillance System. To allow for delays in reporting of HIV diagnoses, cases reported through the end of calendar year following the diagnosis year are included. In addition, standard adjustment for reporting delay is performed. (Song R, Hall HI, Frey R. Uncertainties associated with incidence estimates of HIV/AIDS diagnoses adjusted for reporting delay and risk redistribution. Stat med 2005;24:453-464)

**S.10. Denominator Exclusions** (Brief narrative description of exclusions from the target population)

Persons with month of diagnosis missing are excluded (<0.05%)

**S.11. Denominator Exclusion Details** (All information required to identify and calculate exclusions from the denominator such as definitions, 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)

Month of HIV diagnosis = missing

**S.12. Stratification Details/Variables** (All information required to stratify the measure results including the stratification variables, definitions, 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 with at S.2b)

Results are routinely stratified by age group (13-19, 20-29, 30-39, 40-49, 50-59, >59), by race/ethnicity (white, Hispanic, Black, Asian, Native Hawaiian/other Pacific Islander, AI/AN) and by transmission category (MSM, MSM/IDU, IDU male, IDU female, heterosexual male, heterosexual female, other).

**S.13. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

Stratification by risk category/subgroup

If other:

**S.14. Identify the statistical risk model method and variables** (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

NA

**S.15. Detailed risk model specifications** (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

**S.15a. Detailed risk model specifications** (if not provided in excel or csv file at S.2b)

**S.16. Type of score:**

Rate/proportion

If other:

**S.17. 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 = Lower score

**S.18. Calculation Algorithm/Measure Logic** (Describe the calculation of the measure score as an ordered sequence of steps including

identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

- Based on HIV cases reported through the end of 2011, determine the number of HIV diagnoses in 2010(denominator)
- Among HIV diagnoses made in 2010, determine the number reported as having stage 3 HIV infection (AIDS) diagnosis within 3 months of HIV diagnosis, based on cases reported through the end of 2012(numerator).
- Numerator/denominator x 100 = percent late HIV diagnoses
- Note: data are adjusted for reporting delay according to standard methods (Song R, Hall HI, Frey R. Uncertainties associated with incidence estimates of HIV/AIDS diagnoses adjusted for reporting delay and risk redistribution. Stat med 2005;24:453-464)

**S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment** (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

**S.20. Sampling** (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Measure is calculated for each state using National HIV surveillance system data

**S.21. Survey/Patient-reported data** (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

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

**S.22. Missing data** (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

**S.23. Data Source** (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Other

**S.24. Data Source or Collection Instrument** (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

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

National HIV Surveillance System

**S.25. Data Source or Collection Instrument** (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

**S.26. Level of Analysis** (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Population : Regional and State

**S.27. Care Setting** (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

If other:

**S.28. 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.)

**2a. Reliability** – See attached Measure Testing Submission Form

**2b. Validity** – See attached Measure Testing Submission Form

1999\_MeasureTesting\_MSIF5.0\_Data.doc



### 3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

#### 3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

##### 3a.1. Data Elements Generated as Byproduct of Care Processes.

Other

If other: [calculation based on case reports entered in the surveillance system](#)

#### 3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

**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*)

[ALL data elements are in defined fields in a combination of electronic sources](#)

**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.**

**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.**

Attachment:

#### 3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

**3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.**

**IF a PRO-PM, consider implications for both individuals providing PROM 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*).

### 4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

#### 4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

**4.1. Current and Planned Use**

*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.*

Planned	Current Use (for current use provide URL)
Public Reporting	
Public Health/Disease Surveillance	

**4a.1. For each CURRENT use, checked above, provide:**

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

**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?)

**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.** (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

**4b. Improvement**

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

**4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)**

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (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.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.**

**4c. Unintended Consequences**

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

**4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.**

Not applicable.

**5. Comparison to Related or 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.

#### **5. Relation to Other NQF-endorsed Measures**

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.

##### **5.1a. List of related or competing measures (selected from NQF-endorsed measures)**

##### **5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.**

#### **5a. Harmonization**

The measure specifications are harmonized with related measures;

**OR**

The differences in specifications are justified

##### **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 completely harmonized?**

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

#### **5b. Competing Measures**

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

**OR**

Multiple measures are justified.

##### **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.)**

## **Appendix**

**A.1 Supplemental materials may be provided in an appendix.** All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

**Attachment:**

## **Contact Information**

**Co.1 Measure Steward (Intellectual Property Owner):** [Centers for Disease Control and Prevention](#)

**Co.2 Point of Contact:** [Abigail, Viall, bzv3@cdc.gov](#), 404-639-2010-

**Co.3 Measure Developer if different from Measure Steward:** [Centers for Disease Control and Prevention](#)

**Co.4 Point of Contact:** [Abigail, Viall, bzv3@cdc.gov](#), 404-639-2010-

## **Additional Information**

<b>Ad.1 Workgroup/Expert Panel involved in measure development</b> Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.
<b>Measure Developer/Steward Updates and Ongoing Maintenance</b> <b>Ad.2</b> Year the measure was first released: <b>Ad.3</b> Month and Year of most recent revision: <b>Ad.4</b> What is your frequency for review/update of this measure? <b>Ad.5</b> When is the next scheduled review/update for this measure?
<b>Ad.6 Copyright statement:</b> <a href="#">Not applicable (government entity)</a> <b>Ad.7 Disclaimers:</b> <a href="#">The measure specifications and supporting documentation are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.</a>
<b>Ad.8 Additional Information/Comments:</b>