



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 sub criterion 1b).

Brief Measure Information

NQF #: 2079

Corresponding Measures:

De.2. Measure Title: HIV medical visit frequency

Co.1.1. Measure Steward: Health Resources and Services Administration (HRSA)

De.3. Brief Description of Measure: Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits

A medical visit is any visit in an outpatient/ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.

1b.1. Developer Rationale: Poor retention in care during the first year of outpatient medical care is associated with delayed or failed receipt of antiretroviral therapy, delayed time to virologic suppression and greater cumulative HIV burden, increased sexual risk transmission behaviors, increased risk of long-term adverse clinical events, and low adherence to antiretroviral therapy. Early retention in HIV care has been found to be associated with time to viral load suppression and 2-year cumulative viral load burden among patients newly initiating HIV medical care (8). In this study, each "no show" clinic visit conveyed a 17% increased risk of delayed viral load suppression. A dose- response relationship has been shown between constancy of visits during the first year (i.e. having an HIV primary care visit in each 3-month quarter) and survival. Another study examining care over a two-year period has found that mean increase from baseline CD4 counts was significantly greater among those with optimal retention (visits in all 4 six-month intervals) than among those with sub-optimal retention, and that mortality was higher among those with suboptimal retention.

In 2011, the HIV community saw the emergence of the HIV care continuum. This simple model outlines the sequential steps of medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral suppression. The steps include diagnosis, linkage to care, retention in care, receipt of HIV antiretroviral therapy and viral suppression. This model has been incorporated into the National HIV/AIDS Strategy as it has focused all HIV prevention, care, and treatment efforts in the United States. As outlined in the model, all though there are five different steps, each step is dependent upon each other. For instance, you cannot become virally suppressed if you are not receiving HIV antiretroviral therapy or retained in medical care.

The most recent nationwide data from CDC dated 2014 estimates that although 86% of people living with HIV have been diagnosed, only 40% are engaged in care, 37% have been prescribed HIV antiretroviral therapy, and 30% have achieved viral suppression.

Right now, we are at a very special time and place. Many states and large metropolitan areas across the United States have developed plans to end the HIV epidemic in the communities. These jurisdictions have used the HIV care continuum and its steps as the framework by which they have developed their plans.

S.4. Numerator Statement: Number of patients in the denominator who had at least one medical visit in each 6-month period of the 24-month measurement 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. (Measurement period is a consecutive 24-month period of time.)

S.6. Denominator Statement: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 24-month measurement period.

S.8. Denominator Exclusions: Patients who died at any time during the 24-month measurement period.

De.1. Measure Type: Process

S.17. Data Source: Paper Medical Records

S.20. Level of Analysis: Facility
IF Endorsement Maintenance – Original Endorsement Date: Jan 07, 2013 Most Recent Endorsement Date: Jul 13, 2017
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? Not applicable

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 sub criteria to pass this criterion and be evaluated against the remaining criteria.***

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

[MVF_evidence_NQF-637387186087160205.docx](#), [MVF_submission-636179047812919962-637387186087160205.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

[Yes](#)

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., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Poor retention in care during the first year of outpatient medical care is associated with delayed or failed receipt of antiretroviral therapy, delayed time to virologic suppression and greater cumulative HIV burden, increased sexual risk transmission behaviors, increased risk of long-term adverse clinical events, and low adherence to antiretroviral therapy. Early retention in HIV care has been found to be associated with time to viral load suppression and 2-year cumulative viral load burden among patients newly initiating HIV medical care (8). In this study, each “no show” clinic visit conveyed a 17% increased risk of delayed viral load suppression. A dose- response relationship has been shown between constancy of visits during the first year (i.e. having an HIV primary care visit in each 3-month quarter) and survival. Another study examining care over a two-year period has found that mean increase from baseline CD4 counts was significantly greater among those with optimal retention (visits in all 4 six-month intervals) than among those with sub-optimal retention, and that mortality was higher among those with suboptimal retention.

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the framework by which they have developed their plans.

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 (4b1) under Usability and Use. Please see attachment "MVF submission form" for formatted data.

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.

N/A

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 (4b1) under Usability and Use.

Please see attachment "MVF submission form" for formatted data.

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

N/A

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 sub criteria 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):
Access to Care

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):
Populations at Risk

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.)
<http://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio>

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 not an eMeasure 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 **Attachment:** [Medical_visit_frequency_data_dictionary-637387186083878666.pdf](#)

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

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.

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.

None

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).

Number of patients in the denominator who had at least one medical visit in each 6-month period of the 24-month measurement 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. (Measurement period is a consecutive 24-month period of time.)

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).

To be included in the numerator, patients must have had at least one medical visit in each 6-month period of the 24-month measurement 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.6. Denominator Statement (Brief, narrative description of the target population being measured)

Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 24-month measurement period.

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).

To be included in the denominator, patients must meet all of the following conditions/events:

1. Patients of any age during the measurement period
2. Patients without a date of death during the 24-month measurement period
3. Patients diagnosed with HIV during the first 3 months of the 24-month measurement period or prior to the measurement period
4. Patients who had at least one medical visit in the first 6 months of the 24-month measurement period

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

Patients who died at any time during the 24-month 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.)

Patients with a date of death during the measurement period.

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)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

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 = 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 for data, aggregating data; risk adjustment; etc.)

1. Identify the individuals who satisfy all specific criteria for inclusion in the denominator: 1.) diagnosed with HIV during the first 3 months of the 24-month measurement period or prior to the 24-month measurement period; 2.) did not have a date of death during the 24-month measurement period; and 3.) had at least one medical visit in the first 6 months of the 24-month measurement period. The individuals who met these three criteria are the denominator population.
2. Identify the individuals from the denominator population who meet the criterion for inclusion in the numerator: must have had at least one medical visit in each 6-month period of the 24-month measurement 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.
3. Calculate the rate by dividing the numerator population by the denominator population and multiply by 100.

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

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

Not applicable; not based on a 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.)

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.

Paper Medical Records

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 are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

Electronic or paper records

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

Facility

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

Outpatient Services

If other:

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.

2. Validity – See attached Measure Testing Submission Form

[MVF_testing-637387186089972633.docx](#)

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. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

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. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

No

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1, 2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

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.

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

If other:

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*) Update this field for **maintenance of endorsement**.

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

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.

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. 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 instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

Data availability: The data used for testing and operational use of this measure are readily available within patient health records and provided annually to HIVRN.

Missing date: We were not able to assess for missing data in this submission due to constraints when working with the HIVRN.

Time and frequency of data collection: As noted previously, all variables to calculate this measure are contained in a patient health record in a structured field. These data are routinely collected in the provision of care to people living with HIV. Because the availability of data, sampling is not performed.

Patient confidentiality: The data used in the testing of this measure are deidentified/stripped of personally identifiable information prior to submitting.

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*).

No fees, licensing, or other requirements to use any aspect of the measure.

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.

Specific Plan for Use	Current Use (for current use provide URL)
Public Reporting	<p>Public Health/Disease Surveillance Ryan White HIV/AIDS Program https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio</p> <p>Payment Program PQRS https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqri</p> <p>Quality Improvement (external benchmarking to organizations) Ryan White HIV/AIDS Program https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio</p> <p>Quality Improvement (Internal to the specific organization) Ryan White HIV/AIDS Program https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio</p>

4a1.1 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

Ryan White HIV/AIDS Program

Sponsor: Federal government

Geographic area: Nationwide

Accountable entities: Approximately 600 Ryan White HIV/AIDS Program grant recipients and their providers

Patients: Approximately 316,000 patients

Physician Quality Report System and Value Based Modifier

Sponsor: Federal government

Geographic area: Nationwide

Accountable entities: Physicians and practitioners

Patients: Unknown

Merit-Based Incentive Payment System

Sponsor: Federal government

Geographic area: Nationwide

Accountable entities: Physicians, Physician Assistant, Nurse Practitioner, and Clinical Nurse Specialist

Patients: Unknown

4a1.2. 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

4a1.3. 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.)

N/A

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

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.

4a2.1.2. 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.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

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.

4a2.2.2. Summarize the feedback obtained from those being measured.

See 4d2.2

4a2.2.3. 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.

4a2.3. Describe how the feedback described in 4a2.2.1 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 reviewed 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 requires 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.

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.

4b1. 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.)

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.

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.

4b2. 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).

4b2.1. 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.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

N/A

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.

Yes

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

0403 : HIV/AIDS: Medical Visit

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

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

5a. Harmonization of Related Measures

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 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.

Harmonized with all measures except 405 and 409. Plans to harmonize with 405 and 409.

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.)

This measure does not have a competing measure.

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): Health Resources and Services Administration (HRSA)

Co.2 Point of Contact: Marlene, Matosky, mmatosky@hrsa.gov, 301-443-0798-

Co.3 Measure Developer if different from Measure Steward: Health Resources and Services Administration (HRSA)

Co.4 Point of Contact: Marlene, Matosky, mmatosky@hrsa.gov, 301-443-0798-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

The work group members determined the measure concepts, identified the data elements, voted on the final measures, and assessed the face validity of the measures.

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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2011

Ad.3 Month and Year of most recent revision: 05, 2016

Ad.4 What is your frequency for review/update of this measure? Annual

Ad.5 When is the next scheduled review/update for this measure? 05, 2017

Ad.6 Copyright statement: None

Ad.7 Disclaimers: None

Ad.8 Additional Information/Comments: None