



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 #: 2080

Corresponding Measures:

De.2. Measure Title: Gap in HIV medical visits

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 did not have a medical visit in the last 6 months of the measurement year

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: While prompt linkage to, and sustained retention in, HIV medical care have been clearly shown to maximize patient outcomes, defining and measuring "optimal retention" is not necessarily straightforward, as the most appropriate or useful measure varies according to where the patient is in his/her treatment trajectory (newly diagnosed, recently reengaged in care after some lapse in treatment, or long-time care recipients), who will use the measure (e.g., providers, administrators, or payors), and how the information yielded by the measure will be used.

Retention appears to play a critical role in assisting people living with HIV in their pursuit of achieving viral control and reducing new infections. From an analysis performed by CDC from 2011 data, about 70% of people living with HIV did not have their virus under control. Among the nearly 840,000 people who had not achieved viral suppression, 66% had been diagnosed with HIV, but were not engaged in regular HIV care. A 2015 study estimated the number of HIV transmission from people engaged at the five stages of the HIV care continuum. Ninety-one percent of new HIV infections in 2009 were attributable to people with HIV who were not in medical care, including those who didn't know they were infected. In comparison, less than 6% of new infections could be attributed to people with HIV who were in care and receiving antiretroviral therapy.

It is envisioned that this measure will have a significant impact on patient retention because the patients listed in the numerator are those who require a medical visit. In other words, no additional work needs to be done to generate a list of patients in need of follow-up. A list of the patients in the numerator can be generated, and the medical provider staff can immediately begin follow-up with the patient to schedule an appointment for a medical visit.

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.

<p>S.4. Numerator Statement: Number of patients in the denominator who did not have a medical visit in the last 6 months of the measurement year (Measurement year is a consecutive 12-month period of time).</p> <p>S.6. Denominator Statement: Number of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the first 6 months of the measurement year. (The measurement year can be any consecutive 12-month period.)</p> <p>S.8. Denominator Exclusions: Patients who died at any time during the measurement year.</p>
<p>De.1. Measure Type: Process</p> <p>S.17. Data Source: Other, Paper Medical Records</p> <p>S.20. Level of Analysis: Clinician : Group/Practice, Facility</p>
<p>IF Endorsement Maintenance – Original Endorsement Date: Jan 07, 2013 Most Recent Endorsement Date: Jul 13, 2017</p>
<p>IF this measure is included in a composite, NQF Composite#/title:</p> <p>IF this measure is paired/grouped, NQF#/title:</p> <p>De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? Not applicable</p>

<p>1. Evidence, Performance Gap, Priority – Importance to Measure and Report</p>
<p>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. <i>Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.</i></p>
<p>1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form Gap_evidence-637387186389201479.docx, Gap_submission-637387186389513980.docx</p> <p>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</p>
<p>1b. Performance Gap Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:</p> <ul style="list-style-type: none"> considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or Disparities in care across population groups. <p>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) <i>If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.</i></p> <p>While prompt linkage to, and sustained retention in, HIV medical care have been clearly shown to maximize patient outcomes, defining and measuring “optimal retention” is not necessarily straightforward, as the most appropriate or useful measure varies according to where the patient is in his/her treatment trajectory (newly diagnosed, recently reengaged in care after some lapse in treatment, or long-time care recipients), who will use the measure (e.g., providers, administrators, or payors), and how the information yielded by the measure will be used.</p> <p>Retention appears to play a critical role in assisting people living with HIV in their pursuit of achieving viral control and reducing new infections. From an analysis performed by CDC from 2011 data, about 70% of people living with HIV did not have their virus under control. Among the nearly 840,000 people who had not achieved viral suppression, 66% had been diagnosed with HIV, but were not engaged in regular HIV care. A 2015 study estimated the number of HIV transmission from people engaged at the five stages of the HIV care continuum. Ninety-one percent of new HIV infections in 2009 were attributable to people with HIV who were not in medical care, including those who didn’t know they were infected. In comparison, less than 6% of new infections could be attributed to people with HIV who were in care and receiving antiretroviral therapy.</p> <p>It is envisioned that this measure will have a significant impact on patient retention because the patients listed in the numerator are</p>

those who require a medical visit. In other words, no additional work needs to be done to generate a list of patients in need of follow-up. A list of the patients in the numerator can be generated, and the medical provider staff can immediately begin follow-up with the patient to schedule an appointment for a medical visit.

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.

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 "Gap submission" 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.
See 1b2.

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 "Gap submission" 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):

Care Coordination

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.)

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: [Gap_data_dictionary-637387186385607616.docx](#)

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.

N/A

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 did not have a medical visit in the last 6 months of the measurement year (Measurement year is a consecutive 12-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 not have had a medical visit in the last 6 months of the measurement year.

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

Number of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the first 6 months of the

measurement year. (The measurement year can be any consecutive 12-month 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 year
2. Patients without a date of death during the measurement year
3. Patients diagnosed with HIV during the first 3 months of the measurement year or prior to the measurement year
4. Patients who had at least one medical visit in the first 6 months of the measurement year

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

Patients who died at any time during the measurement year.

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 year.

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 = Lower 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.) had a HIV diagnosis prior to the measurement year or during the first three months of the measurement year; 2.) did not have a date of death during the measurement year; and 3.) had at least one medical visit in the first 6 months of the measurement year. 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: did not have a medical visit in the last 6 months of the measurement year.
3. Calculate the percentage 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.

S.17. Data Source (Check *ONLY* the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Other, 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.

Not applicable.

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)

Clinician : Group/Practice, 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.)

N/A

2. Validity – See attached Measure Testing Submission Form

[Gap_testing-637387186392796661.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.

Yes

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).

For this measure, we are currently field testing (beta testing) an electronically specified measure.

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 collection and availability: The data used for testing and operational use of this measure are readily available within patient health records and provided annually to the Ryan White HIV/AIDS Program through the reporting of the Ryan White Service Report (approved by the Office of Management and Budget 0915-0323).

Missing data: A full analysis of missing data is provided in this submission.

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)
	<p>Public Reporting</p> <p>Ryan White HIV/AIDS Program https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio</p> <p>Payment Program</p> <p>Ryan White HIV/AIDS Program https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio</p> <p>Quality Improvement (external benchmarking to organizations)</p> <p>Ryan White HIV/AIDS Program https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio</p> <p>Quality Improvement (Internal to the specific organization)</p> <p>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

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.

Starting in 2015, Health Resources and Services Administration began releasing December 1st – World AIDS Day – an annual data report (Ryan White HIV/AIDS Program Annual Client-Level Data Report) that contains data similar to those presenting in the report. Building upon the success of the state profiles (<http://hab.hrsa.gov/stateprofiles/>), Health Resources and Services Administration worked diligently to release the annual data report in the same year it was collected (collected in April and released in December of the same year). The report is publicly available on the Health Resources and Services Administration website (<http://hab.hrsa.gov/data/data-reports>) and is released via an accompanying webinar (recorded and archived). A supplemental report exploring data for the eligible metropolitan areas and transitional grant areas and youth/young adults has been released as well as slides sets for fact sheets by program and population, special populations (<http://hab.hrsa.gov/publications/hiv-aids-bureau-fact-sheets>), and infographics (contained in fact sheets). Additionally, grant recipient level reports are prepared and disseminated to all Ryan White HIV/AIDS Program grant recipients.

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.

Starting in 2015, Health Resources and Services Administration began releasing December 1st – World AIDS Day – an annual data report (Ryan White HIV/AIDS Program Annual Client-Level Data Report) that contains data similar to those presenting in the report. Building upon the success of the state profiles (<http://hab.hrsa.gov/stateprofiles/>), Health Resources and Services Administration worked diligently to release the annual data report in the same year it was collected (collected in April and released in December of the same year). The report is publicly available on the Health Resources and Services Administration website (<http://hab.hrsa.gov/data/data-reports>) and is released via an accompanying webinar (recorded and archived). A supplemental report exploring data for the eligible metropolitan areas and transitional grant areas and youth/young adults has been released as well as slides sets for fact sheets by program and population, special populations (<http://hab.hrsa.gov/publications/hiv-aids-bureau-fact-sheets>), and infographics (contained in fact sheets). Additionally, grant recipient level reports are prepared and disseminated to all Ryan White HIV/AIDS Program grant recipients.

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 from Ryan White HIV/AIDS Program grant recipients and subrecipients regarding the feasibility and usefulness of the data presented in the Ryan White HIV/AIDS Program Annual Client-Level Data Report. Significant feedback has been provided about the timeliness and expansions of the data release. Grant recipient report using the data for benchmarking their program, setting goals/targets, and gaining a fuller understanding of all aspects of the Ryan White HIV/AIDS Program (i.e. other regions of the country). Grant recipients and subrecipients have also requested additional analyses. Health Resources and Services Administration responded with supplemental reports (Ryan White HIV/AIDS Program Supplemental Client-Level Data Report, Eligible Metropolitan Areas and Transitional Grant Areas; special population reports); slide decks for the overall client population and special populations; grant recipient reports; and infographics – all of which will be updated and released annually. Health Resources and Services Administration plans to release additional analyses and special reports this year based on feedback from Ryan White HIV/AIDS Program grant recipients and subrecipients.

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

Ryan White HIV/AIDS Program national partners (national organizations that represent grant recipients, subrecipients, and patients) has provided antidotal feedback regarding the timeliness, feasibility, and usability of the release of the Ryan White HIV/AIDS Program Annual Client-Level Data Report, supplemental reports, slide decks, fact sheets, and infographics. The national partners encourage the continued release of the data in all its formats.

4a2.2.3. Summarize the feedback obtained from other users

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.

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.

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.

The Ryan White HIV/AIDS Program served more than 300,000 unduplicated patients annually between 2010-2014 across 2,000+ grant recipients and subrecipients. Gap in HIV medical visits has seem small increases over the past few years. Antidotal information suggests that retention has become less of a priority even though a significant number of HIV transmission have been linked to people who are not retained in medical care. The Ryan White HIV/AIDS Program has experienced a 3-point increase in gap in HIV medical visits from 18.6% in 2010 to 21.7% in 2014. This increase has been experienced across most of the demographic populations.

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 submitted for adoption or 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)

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

2079 HIV Medical Visit Frequency

208 HIV Viral Suppression

2083 Prescription of HIV Antiretroviral Therapy

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.

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.)

N/A

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.

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

Bruce Agins, NYS DOH AIDS Institute, New York, NY
Judy Bradford, Fenway Community Health, Boston, MA
John Brooks, CDC, Atlanta, GA
Karen Brudney, Columbia University, New York, NY
Laura Cheever, HRSA HAB, Rockville, MD
Nikki Cockern, Wayne State University, Detroit, MI
Chinazo Cunningham, Montefiore Medical Center, New York, NY
William Cunningham, UCLA, Los Angeles, CA
Julie Dombrowski, University of Washington, Seattle, WA
Edward Gardner, Denver Health, Denver, CO
Elvin Geng, UCSF, San Francisco, CA
Thomas Giordano, Baylor College of Medicine, Houston, TX
Barb Gripshover, Cleveland ACT UP, Cleveland, OH
Deborah Konkle Parker, University of Mississippi, Jackson, MS
Tim Long, Alliance Chicago, Chicago, IL
Cheryl Lynn-Besch, Louisiana State University, New Orleans, LA
Julio Marrero, COSSMA, San Juan, PR
Brian Montague, Brown University, Providence, RI
Karam Mounzer, Philadelphia Fight, Philadelphia, PA
Michael Mugavero, University of Alabama, Birmingham, AL
Sylvia Naar King, Wayne State University, Detroit, MI
Josiah Rich, Brown University, Providence, RI
Allan Rodriguez, Miami University, Miami, FL
Amy Sitapati, UCSD, San Diego, CA
Avnish Tripathi, University of South Carolina, Charleston, SC
Gregory Winstead, Christian Community Health Center, Chicago, IL

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.

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: It is our intention that this measure will be used in quality improvement in addition to public reporting. As it is involved in quality improvement, it is not our intent that the performance goal will be 0%. When we do set the performance goal, we will take into consideration appropriate reasons why the patient may not be able to meet the numerator criterion.