



## 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 #:** 0029

**Corresponding Measures:**

**De.2. Measure Title:** Physical Activity in Older Adults (PAO)

**Co.1.1. Measure Steward:** National Committee for Quality Assurance

**De.3. Brief Description of Measure:** This measure has two rates that assess the promotion of physical activity in older adults:

Discussing Physical Activity: Percentage patients 65 years of age and older who reported discussing their level of exercise or physical activity with a doctor or other health provider in the last 12 months

Advising Physical Activity: Percentage patients 65 years of age and older who reported receiving advice to start, increase, or maintain their level of exercise or physical activity from a doctor or other health provider in the last 12 months

**1b.1. Developer Rationale:** Encouraging older adults to increase physical activity will help prevent disease and improve the health of older adults who already suffer from chronic conditions and declining function. While health care cost savings were found across age groups, genders, smokers and nonsmokers and people with or without physical limitations, older adults stand to benefit the most from increased activity.

**S.4. Numerator Statement:** Discussing physical activity:

The number of patients in the denominator who responded "yes" to the question, "In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical activity."

Advising physical activity:

The number of patients in the denominator who responded "yes" to the question, "In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program."

**S.7. Denominator Statement:** Medicare patients age 65 years and older who reported having had a visit to a health care provider in the past 12 months.

**S.10. Denominator Exclusions:** N/A

**De.1. Measure Type:** Process

**S.23. Data Source:** Instrument-Based Data

**S.26. Level of Analysis:** Health Plan, Integrated Delivery System

**IF Endorsement Maintenance – Original Endorsement Date:** Aug 10, 2009 **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?** N/A

## 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

0029\_Evidence\_MSF5.0\_Data.doc

### 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)

Encouraging older adults to increase physical activity will help prevent disease and improve the health of older adults who already suffer from chronic conditions and declining function. While health care cost savings were found across age groups, genders, smokers and nonsmokers and people with or without physical limitations, older adults stand to benefit the most from increased activity.

**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.**

#### Adults Discussion Rate

Data Element; 2009; 2008; 2007;

N (Health plans); 465; 419; 357;

MEAN; 52.5; 51.9; 52;

STDEV; 5.68; 5.83; 5.47;

STDERR; 0.26; 0.29; 0.29;

MIN; 32.2; 31.3; 36.2;

MAX; 65.6; 66.4; 64.9;

P10; 45; 44.1; 45;

P25; 48.7; 48; 48.4;

P50; 52.9; 52.2; 51.8;

P75; 56.6; 56.3; 56;

P90; 59.7; 59.8; 59.1;

#### Adults Advise Rate

Data Element; 2009; 2008; 2007;

N (Health plans); 465; 419; 357;

MEAN; 47.6; 46.9; 46.8;

STDEV; 5.06; 5.2; 5.21;

STDERR; 0.23; 0.25; 0.28;

MIN; 28.3; 29.1; 29.6;

MAX; 62.6; 62.2; 66;

P10; 41.5; 40.2; 40.5;

P25; 44.3; 43.6; 43.5;

P50; 47.8; 46.9; 46.4;

P75; 50.8; 50.1; 50.4;

P90; 53.8; 53.2; 53;

Across Medicare plans, the rates for the discussing physical activity and advising physical activity have shown little change. The national average for 2007 was 52.0% for discussing and 46.8% for advising physical activity, with a range of about 13-14% between the 10th percentile and the 90th percentile on both rates. In 2008, this average decreased slightly to 51.9% for discussing and

increased very slightly to 46.9% for advising. By 2009, only very slight increases were again observed (to 52.5% discussing and 47.6% advising). The 10th to 90th percentile variation also remained steady between 2007 and 2009. These performance reports indicate room for improvement.

**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.**

Section 1b.2 references data from the most recent three years of measurement for HEDIS. The data in section 1b.2 includes percentiles, mean, min, max, standard deviation and standard errors. These data are calculated at the health plan level.

**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.*

NCQA has participated with IOM and others in attempting to include information on disparities in measure data collection. However, at the present time, this data, at all levels (claims data, paper chart review, and electronic records), is not coded in a standard manner, and is incompletely captured. There are no consistent standards for what entity (physician, group, plan, employer) should capture and report this data. While “requiring” reporting of the data could push the field forward, it has been our position that doing so would create substantial burden with inability to use the data because of its inconsistency. At the present time, we agree with the IOM report that disparities are best considered by the use of zip code analysis which has limited applicability in most reporting situations. At the health plan level, for HEDIS health plan data collection, NCQA does have extensive data related to our use of stratification by insurance status (Medicare, Medicaid and private-commercial) and would strongly recommend this process where the data base supporting the measurement includes this information. However, we believe that the measure specifications should NOT require this since the measure is still useful where the data needed to determine disparities cannot be ascertained from the data available.

**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.**

N/A

**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**

Affects large numbers, Patient/societal consequences of poor quality

**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.**

Older adults age 65 and above are one of the fastest growing age groups in the United States (U.S. Bureau of Census, 2009). Various studies, including recent meta-analyses, have shown that physical activity is strongly associated with maintaining or slowing declines in function, cognition, and health-related quality of life (QOL) among older adults, yet only a small proportion of this population is engaged in regular physical activity (Angevaren et al 2008; Liu & Fielding, 2011; Motl & McAuley, 2010). Perceived barriers of the elderly towards physical activity can be personal or environmental, including physical health problems and physical frailty, fear of resultant injury or falling, past sedentary lifestyle, insufficient understanding about physical activity and environmental restriction (Chen, 2010).

Chronic conditions related to physical inactivity are major contributors to health care costs in the United States. Most older adults suffer from at least one chronic condition for which there is a clinical guideline recommending physicians to counsel patients to exercise (AHRQ, 2002). Five of the major chronic conditions account for 32.7 percent of U.S. health care expenditures (\$1.9 trillion

overall in 2004) (AHRQ, 2006). Older adults are at particular risk for sedentary lifestyles. The loss of strength and stamina attributed to aging is in part caused by reduced physical activity over time. Inactivity increases with age. By age 75, about one in three men and one in two women engage in no physical activity (CDC,1999). Older adults can obtain significant health benefits even with a moderate amount of physical activity, including longer sessions of moderately intense activities (e.g.,walking) or shorter sessions of more vigorous activities (e.g., fast walking or stairwalking), and effective intervention to promote physical activity in older adults merit wide implementation (CDC 1999; King, 2007).

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

Agency for Healthcare Research and Quality. (2006). The High Concentration of U.S. Health Care Expenditures. Available at: <http://www.ahrq.gov/research/ria19/pendria.pdf>.

Agency for Healthcare Research and Quality. (2002) Physical Activity and Older Americans: Benefits and Strategies.Available at: <http://www.ahrq.gov/ppip/activity.htm>.

Angevaren M, Aufdemkampe G, Verhaar HJ, et al. (2008). Physical Activity and Enhanced Fitness to Improve Cognitive Function in Older People Without Known Cognitive Impairment. Cochrane Database Syst Rev. 16(2):CD005381.

Centers for Disease Control. Physical Activity and Health Older Adults.1999 <http://www.cdc.gov/nccdphp/sgr/olderad.htm>.

Chen YM. (2010). Perceived Barriers to Physical Activity Among Older Adults Residing in Long-Term Care Institutions. Journal of Clinical Nursing; 19(3-4):432-9.

King AC, Castaneda CA, Sceppe MC, et al. (2007). Physical Activity and Public Health in Older Adults. Recommendation from the American College of Sports Medicine and the American Heart Association. Circulation. 116:1094-1105.

Liu CK & Fielding RA. (2011). Exercise as an Intervention for Frailty. Clinics in Geriatric Medicine; 27(1):101-10.

Motl RW & McAuley E. (2010). Physical Activity, Disability, and Quality of Life in Older Adults. Physical Medicine and Rehabilitation Clinics of North America; 21(2):299-308.

US Bureau of the Census. (2009). Age and Sex. In: 2005-2009 American Community Survey.

**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):

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

Primary Prevention

**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)

No data dictionary 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.

Discussing physical activity:

The number of patients in the denominator who responded “yes” to the question, “In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical activity.”

Advising physical activity:

The number of patients in the denominator who responded “yes” to the question, “In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.”

**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.)

The measurement year (12 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.

This measure is collected through the Medicare Health Outcomes Survey - a national survey of Medicare Advantage Organization members. The survey is collected through mail with a telephone follow up. The two rates for this measure are collected through the following questions.

Discussing physical activity: Response of “yes” to Q46 in the Medicare Health Outcomes Survey (HOS):

“In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical activity.”

Advising physical activity: Response of “yes” to Q47 in the Medicare Health Outcomes Survey (HOS):

“In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.”

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

Medicare patients age 65 years and older who reported having had a visit to a health care provider in the past 12 months.

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

Elderly, Populations at Risk : Dual eligible beneficiaries, Populations at Risk : Individuals with multiple chronic conditions

**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)

Discussing physical activity:

The number of Medicare patients 65 years and older as of the end of the measurement year who responded “yes” or “no” to Q46 in

the Health Outcomes Survey “In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical activity.” Patients who respond “I had no visit in the past 12 months” are not included in the denominator.

**Advising Physical activity:**

The number of Medicare patients 65 years and older as of the end of the measurement year who responded “yes” or “no” to Q47 in the Health Outcomes Survey, “In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.” Patients who respond “I had no visit in the past 12 months” for Q46 are not included in the denominator.

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

N/A

**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)

N/A

**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)

N/A

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

No risk adjustment or risk stratification

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)

**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 = Higher 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.)

Discussing Physical Activity

Step 1: Identify the eligible population (Medicare patients aged 65 years and older)

Step 2: Identify the denominator (patients responding “yes” or “no” to the Q46; patients responding “I had no visit in the past 12

months are not included in the denominator)

Step 3: Identify the numerator (patients in the denominator responding yes to Q46)

Step 4: Discussing Physical Activity rate is calculated by dividing the numerator by the denominator

#### Advising Physical Activity

Step 1: Identify the eligible population (Medicare patients aged 65 years and older)

Step 2: Identify the denominator (patients responding “yes” or “no” to the Q47; patients responding “I had no visit in the past 12 months” for Q46 are not included in the denominator)

Step 3: Identify the numerator (patients in the denominator responding yes to Q47)

Step 4: Advising Physical Activity rate is calculated by dividing the numerator by the denominator

**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.

The measure is collected in the Medicare Health Outcomes Survey (HOS). Medicare Advantage Organizations (MAOs) reporting the measure must contract with a NCQA-Certified HOS Survey Vendor to administer the survey. A minimum of 1,200 members per MAO are randomly selected for the survey. MAOs must achieve a denominator of at least 100 to obtain a reportable result (e.g. at least 100 members responding “yes” or “no” to the question). If the denominator is less than 100, NCQA assigns a measure result of NA.

NCQA outlines the sampling criteria for all HOS measures. The complete data collection method and sampling guidelines are outlined in NCQA’s HEDIS Technical Specifications for the HOS, Volume 6.

**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.

[Instrument-Based Data](#)

**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.

[Medicare Health Outcomes Survey](#)

**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)

[URL](#)

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

[Health Plan, Integrated Delivery System](#)

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

[Outpatient Services, Post-Acute Care](#)

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

[0029\\_MeasureTesting\\_MSFS.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: [Patient-reported health survey](#)

#### 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)*

[No data elements are in defined fields in 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.**

[Data are collected via a patient mail \(or telephone\) survey. Electronic surveys may be available in the future.](#)

**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.**

[This measure is precisely specified using the survey data collection method. This measure has detailed, precise specifications that clearly define the numerator, denominator, data sources, allowable values, methods of measurement and method of reporting.](#)

[The Geriatric Measurement Advisory Panel which developed the measure considered several measurement methods to evaluate provider counseling of physical activity. Due to poor coding of physician counseling in administrative claims data and poor documentation in medical records it was determined that a measure using administrative or medical record data would be difficult and unreliable. Survey questions to assess whether elderly received physician counseling were considered most reliable and accurate method.](#)



To ensure survey questions are reliable and valid, the questions were cognitively tested to identify any difficulty with the wording and response choices. Results of cognitive testing were used to further refine the survey questions comprising the measure.

**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	
Payment Program	
Quality Improvement (Internal to the specific organization)	

#### 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.**

NCQA recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may vary, and other errors may taint the results, diminishing the usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO's ability to comply with HEDIS specifications (. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.

The HEDIS Compliance Audit addresses the following functions:

- 1) information practices and control procedures
- 2) sampling methods and procedures
- 3) data integrity
- 4) compliance with HEDIS specifications
- 5) analytic file production
- 6) reporting and documentation

## **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.)**

[NCQA realizes there may be competing measures that exist and welcomes the opportunity to explore harmonization.](#)

## **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):** [National Committee for Quality Assurance](#)

**Co.2 Point of Contact:** [Bob, Rehm, \[nqf@ncqa.org\]\(mailto:nqf@ncqa.org\), 202-955-1728-](#)

**Co.3 Measure Developer if different from Measure Steward:** [National Committee for Quality Assurance](#)

**Co.4 Point of Contact:** [Jill Marie, Farrell, \[farrell@ncqa.org\]\(mailto:farrell@ncqa.org\), 202-955-3599-](#)

## **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.**

[Geriatrics MAP](#)

[Wade Aubry, BCBS Association](#)

[Arlene Bierman, University of Toronto and St. Michael's Hospital](#)

[Joyce Dubow, AARP](#)

[Peter Hollmann, BCBS of Rhode Island](#)

[Jerry Johnson, University of Pennsylvania](#)

[David Martin, Ovations](#)

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Jeffrey Kelman  
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Rosemary Lee  
Alice Lee Martin  
Chris Haffer  
Sonya Bowen  
Mary B. Barton

The NCQA Geriatric Measurement Advisory Panel advised NCQA during measure development. They evaluated the way staff specified measures, assessed the content validity of measures, and reviewed cognitive testing results. As you can see from the list, the MAP consisted of a balanced group of experts, including representatives from medical research and education, health plans, the federal Medicare program, and older adult associations. Note that, in addition to the MAP, we also vetted these measures with a host of other stakeholders, as is our process. Thus, our measures are the result of consensus from a broad and diverse group of stakeholders, in addition to the MAP.

Committee on Performance Measurement (CPM)  
Peter Bach, MD, Memorial Sloan Kettering Cancer Center  
Bruce Bagley, MD, American Academy of Family Physicians  
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Susan Reinhard, RN, PhD, AARP  
Ted Rooney, RN, MPH, Pathways to Excellence  
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Jane E. Sisk, PhD, Division of Health Care Statistics  
Kevin Weiss, MD, FACP, American Board of Medical Specialties

**Measure Developer/Steward Updates and Ongoing Maintenance**

**Ad.2 Year the measure was first released:** 2005

**Ad.3 Month and Year of most recent revision:** 11, 2009

**Ad.4 What is your frequency for review/update of this measure?** Approximately every three years; sooner if the clinical guidelines change significantly

**Ad.5 When is the next scheduled review/update for this measure?** 07, 2013

**Ad.6 Copyright statement:** © 2012 by the National Committee for Quality Assurance

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**Ad.7 Disclaimers:** No changes have been made to this measure

**Ad.8 Additional Information/Comments:**