

# NATIONAL QUALITY FORUM

## Measure Submission and Evaluation Worksheet 5.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the [submitting standards web page](#).

<b>NQF #:</b> 0620	<b>NQF Project:</b> Pulmonary Project
(for Endorsement Maintenance Review)	
<b>Original Endorsement Date:</b> Dec 04, 2009 <b>Most Recent Endorsement Date:</b> Dec 04, 2009 <b>Last Updated Date:</b> Oct 19, 2012	
<b>BRIEF MEASURE INFORMATION</b>	
<b>De.1 Measure Title:</b> Asthma - Short-Acting Beta Agonist Inhaler for Rescue Therapy	
<b>Co.1.1 Measure Steward:</b> ActiveHealth Management	
<b>De.2 Brief Description of Measure:</b> The percentage of patients 2 years or older with asthma who have a refill for a short-acting beta agonist in the past 12 months.	
<b>2a1.1 Numerator Statement:</b> Patients who have at least one refill for a short acting beta agonist for rescue therapy in the past 12 months.	
<b>2a1.4 Denominator Statement:</b> Patients 2 years and older with a diagnosis of asthma who had at least one office visit in the past 12 months.	
<b>2a1.8 Denominator Exclusions:</b> 1.General exclusion for Terminal Illness 2.General exclusion for cancer 3.Provider or patient feedback stating patient does not have a diagnosis of asthma	
<b>1.1 Measure Type:</b> Process	
<b>2a1. 25-26 Data Source:</b> Claims, Electronic Health Data, Electronic Health Records, Instrument-Based Data, Other	
<b>2a1.33 Level of Analysis:</b> Clinician : Group/Practice, Clinician : Individual, Facility, Health Plan, Integrated Delivery System, Other, Population : Community, County or City, Population : Regional and State	
<b>1.2-1.4 Is this measure paired with another measure?</b> No	
<b>De.3 If included in a composite, please identify the composite measure (title and NQF number if endorsed):</b> Not applicable.	

<b>STAFF NOTES</b> (issues or questions regarding any criteria)
<b>Comments on Conditions for Consideration:</b>
<b>Is the measure untested?</b> Yes <input checked="" type="radio"/> No <input checked="" type="radio"/> If untested, explain how it meets criteria for consideration for time-limited endorsement:
<b>1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (check De.5):</b>
<b>5. Similar/related <a href="#">endorsed</a> or submitted measures (check 5.1):</b>
<b>Other Criteria:</b>

Staff Reviewer Name(s):

## 1. IMPACT, OPPORTUNITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT

Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See [guidance on evidence](#).

**Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)**

**1a. High Impact:** H ☒ M ☒ L ☐ I ☐ NA

(The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.)

**De.4 Subject/Topic Areas** (Check all the areas that apply): Respiratory : Asthma

**De.5 Non-Condition Specific** (Check all the areas that apply): Population Health

**1a.1 Demonstrated High Impact Aspect of Healthcare:** Affects large numbers, High resource use

**1a.2 If "Other," please describe:**

**1a.3 Summary of Evidence of High Impact** (Provide epidemiologic or resource use data):

In 2009, current asthma prevalence was 8.2%, affecting 24.6 million people in the United States (17.5 million adults and 7.1 million children aged 0–17 years). Asthma attack prevalence—the proportion of the population with at least one attack in the previous year—was 4.2%. That is, 12.8 million people (8.7 million adults and 4.0 million children aged 0–17), or 52% of those with current asthma, had attacks and were at risk for adverse outcomes such as ED visits or hospitalization. The measure most comparable to the pre-1997 asthma period prevalence estimate is current asthma prevalence, which had remained stable (at 7.4%) since it first became available in 2001 but recently began increasing so that overall, the annual percentage increase from 2001 to 2009 was 1.2%. Asthma attack prevalence remained level between 3.9% and 4.3% during 1997–2009.

In 2007, 13.9 million visits for asthma were made to private physician offices (7.2 million for adults and 6.7 million for children aged 0–17 years) and 1.4 million visits to hospital OPDs (0.6 million for adults and 0.8 million for children aged 0–17 years). The National Heart, Lung, and Blood Institute guidelines for the clinical management of asthma recommend periodic preventive ambulatory visits for asthma monitoring, and a proportion of visits in nonemergent ambulatory settings may reflect appropriate disease management. In contrast, visits to EDs and hospital stays for asthma represent adverse outcomes. There were 1.75 million ED visits (1.11 million for adults and 0.64 million for children aged 0–17) and 456,000 asthma hospitalizations (299,000 for adults and 157,000 for children aged 0–17). There were 3,447 deaths due to asthma in 2007 (3,262 among adults and 185 among children aged 0–17). (1)

For adults, asthma is the fourth leading cause of work absenteeism and "presenteeism," resulting in nearly 15 million missed or lost workdays each year, resulting in a total cost of nearly \$3 billion in total lost productivity. (2)

**1a.4 Citations for Evidence of High Impact cited in 1a.3:** 1. National Health Statistics Reports, Asthma Prevalence, Health Care Use, and Mortality: United States, 2005-2009

<http://www.cdc.gov/nchs/data/nhsr>

2. Morbidity and Mortality Weekly Report, "Surveillance for Asthma, U.S. CDC, 2002

**1b. Opportunity for Improvement:** H ☒ M ☒ L ☐ I ☐ NA

(There is a demonstrated performance gap - variability or overall less than optimal performance)

**1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:**

12.8 million or 52% of asthmatics will have an attack with an adverse outcome requiring a visit to the emergency room or hospitalization. Appropriate management for patients with asthma should include education on medication adherence, proper use of rescue therapy (i.e., inhaler, nebulizer), and an asthma action plan which includes the recognition of early signs and symptoms of an asthma attack. This measure is aimed at ensuring that patients with asthma have appropriate medication available for rescue therapy in the event of an acute asthma exacerbation, with the intent of decreased emergency room and hospital visits.

**1b.2 Summary of Data Demonstrating Performance Gap** (*Variation or overall less than optimal performance across providers*): [**For Maintenance** – *Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.*]

There is very limited published data regarding asthmatics and the presence of short acting beta-agonists to prevent asthma attacks requiring a visit to the hospital or emergency room. ActiveHealth benchmark data has demonstrated that gaps can be detected. Our 2011 data identified 42% asthmatics who did not have any rescue therapy available in the past 1 year.

**1b.3 Citations for Data on Performance Gap:** [**For Maintenance** – *Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]

Confidential ActiveHealth Management data for 2011 Performance Measures.

**1b.4 Summary of Data on Disparities by Population Group:** [**For Maintenance** – *Descriptive statistics for performance results for this measure by population group*]

African Americans are three times more likely to be hospitalized from asthma<sup>1</sup>. African American women have the highest asthma mortality rate of all groups, more than 2.5 times higher than Caucasian women.<sup>(1)</sup>

Despite the fact that in 2002, over 1.7 million Hispanic Americans reported that they currently have asthma and 1.1 million experienced an asthma attack in the past year, Hispanics have lower rates of asthma than non-Hispanic blacks and whites. <sup>(2)</sup>

There was no difference observed between blacks and white with respect to total ambulatory visits. The rate was higher among blacks than whites with respect to ED visits, hospitalizations, and deaths. Children had a tendency to use more health services compared to adults. Among children aged 0–4 rates per 100 persons with current asthma for total ambulatory visits were 144.9, for ED visits 24.6, and for hospitalizations 8.4. However, deaths from asthma are rare among children aged 0–17, with 174 deaths on average per year from 2005–2007.<sup>(3)</sup>

The cornerstone of clinical guidelines for the management of asthma is control of symptoms and prevention of adverse outcomes.<sup>(4)</sup> In 2008, about 96% of people with current asthma reported that a health professional taught them how to use their inhaler, nearly meeting the target of 98.8%. However, 34% reported receiving an asthma management plan with specific instructions on how to change the amount or type of medicine taken, when to call a doctor for advice, and when to go to the ED, and 60% reported that they were taught how to recognize early signs and symptoms of an asthma episode. Report of receiving these asthma control strategies differed among groups, with generally higher rates among children than adults and among non-Hispanic black persons than non-Hispanic white and Mexican persons.

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type of medicine taken, when to call a doctor for advice, and when to go to the ED, and 60% reported that they were taught how to recognize early signs and symptoms of an asthma episode. Report of receiving these asthma control strategies differed among groups, with generally higher rates among children than adults and among non-Hispanic black persons than non-Hispanic white and Mexican persons.

**1b.5 Citations for Data on Disparities Cited in 1b.4: [For Maintenance – Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included]**

1. "Asthma: A Concern for Minority Populations," NIAID, NIH 2001

2. Asthma and Latino Cultures: Different Prevalence Reported Among Groups Sharing the Same Environment," American Journal of Public Health, 2000

3. National Health Statistics Reports, Asthma Prevalence, Health Care Use, and Mortality: United States, 2005-2009

<http://www.cdc.gov/nchs/data/nhsr>

4. National Asthma Education and Prevention Program. Expert Panel Report 3: Guidelines for the diagnosis and management of asthma. NIH pub no 07-4051. Bethesda, MD: National Heart, Lung, and Blood Institute, National Institutes of Health. 2007. Available from: <http://www.nhlbi.nih.gov/guidelines/asthma/>.

**1c. Evidence** (Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.)

Is the measure focus a health outcome? Yes ☐ No ☐ **If not a health outcome, rate the body of evidence.**

Quantity: H ☐ M ☐ L ☐ I ☐ Quality: H ☐ M ☐ L ☐ I ☐ Consistency: H ☐ M ☐ L ☐ I ☐

Quantity	Quality	Consistency	Does the measure pass subcriterion 1c?
M-H	M-H	M-H	Yes <input type="radio"/>
L	M-H	M	Yes <input type="radio"/> IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise No <input type="radio"/>
M-H	L	M-H	Yes <input type="radio"/> IF potential benefits to patients clearly outweigh potential harms: otherwise No <input type="radio"/>
L-M-H	L-M-H	L	No <input type="radio"/>

**Health outcome** – rationale supports relationship to at least one healthcare structure, process, intervention, or service

**Does the measure pass subcriterion 1c?**  
Yes ☐ IF rationale supports relationship

**1c.1 Structure-Process-Outcome Relationship** (Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process-health outcome; intermediate clinical outcome-health outcome):

Our process measure is focused on increasing the number of asthma patients who have access to at least one prescription of a short acting-beta agonist in the calendar year. Access to rescue therapy should result in improvement of the intermediate clinical outcome of decreased emergency room and hospital visits associated with acute asthma exacerbations and ultimately decreasing morbidity rates of asthma patients.

**1c.2-3 Type of Evidence** (Check all that apply):  
Clinical Practice Guideline

**1c.4 Directness of Evidence to the Specified Measure** (State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population):

There are no major studies formally assessing the absence of rescue therapy in asthmatics. Short-acting beta-agonists are the standard of treatment for acute symptoms of bronchospasm. Our measure focus is aligned with current standard of medical care in asthmatics and measures the correct target population.

**1c.5 Quantity of Studies in the Body of Evidence** (Total number of studies, not articles): We reviewed 40 publications (guidelines, studies, abstracts) of this population were identified in the past 5 years. Of these, 7 were applicable to our patient population, 4 randomized double-blind placebo controlled trials and 3 prospective trials assessing the safety and efficacy of short acting beta-agonist therapy.

**1c.6 Quality of Body of Evidence** (Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events): There is very limited published data regarding asthmatics and the presence of short acting beta-agonists to prevent asthma attacks requiring a visit to the hospital or emergency room. There is indirect evidence that the presence of at least one prescription of short acting-beta agonists in the calendar year can result in the reduction of emergency room and hospital visits. There is good evidence that bronchodilators such as short acting beta-agonists relieve the symptoms of an asthma attack.

A Cochrane Database review conducted by Walters et al. reviewed the literature with respect to prn short acting beta-agonists or regular (chronic) use. 44 studies were included, each of these studies compared the use of regular inhaled short acting beta-2 agonist with placebo. 28 studies compared the regular use of inhaled short acting beta-2 agonists with placebo, a short acting agent also being used for rescue use. 16 studies (21 treatment comparisons) compared regular inhaled short acting beta-2 agonist use with placebo and the rescue agent was not a short acting beta-2 agonist. The reviewers used the method of Jadad on a scale from 0-5 (1. Was the study described as randomized? (1=yes, 0=no) 2. Was the study described as double-blind?(1=yes, 0=no) 3. Was there a description of withdrawals and drop outs? (1=yes, 0=no) 4. Was the method of randomization well described and appropriate? (1=yes, 0=no) 5. Was the method of double-blinding well described and appropriate? (1=yes, 0=no) 6. Deduct 1 point if methods of randomization or blinding were inappropriate) to assess the validity of each study.

There was little difference between the treatments for nearly all outcomes. In cross-over studies, evening peak flow was better with regular treatment, weighted mean difference (WMD) 13.1 l/min (95% confidence interval 24.3, 1.9). In contrast, the FEV1 was better with as-needed treatment (WMD 157 ml (95% CI: 123, 192). Bronchial hyper reactivity was slightly better in the as-needed group, standardized mean difference 0.23, 95% CI: 0.52, 1.121. There was no significant difference in the odds ratio for the occurrence of at least one major asthma exacerbation either in parallel group or cross over studies. These results support current guidelines with respect to prn rescue therapy with short acting beta-agonists.

**Citation:**

1. Walters EH, Walters JAE, Gibson PG, Jones P. Inhaled short acting beta2-agonist use in chronic asthma: regular versus as needed treatment. Cochrane Database of Systematic Reviews 2003, Issue 1. Art.No.: CD001285. DOI: 10.1002/14651858.CD001285.

**1c.7 Consistency of Results across Studies** (Summarize the consistency of the magnitude and direction of the effect): There are no randomized, controlled, intervention trials testing the absence of short acting beta-agonists as they relate to emergency room and hospital visits. It would be unethical to conduct such a study, considering the fact that short acting beta-agonists are a vital part of Step 1 therapy as outlined in the EPR-3 guidelines. Many studies have shown that compliance with asthma meds is an issue especially with preventive medications and remains an area for improvement.

**Citation:**

1. National Asthma Education and Prevention Program. Expert Panel Report 3: Guidelines for the diagnosis and management of asthma. Pg.236 . Bethesda, MD: National Heart, Lung, and Blood Institute, National Institutes of Health. 2007. Available from: <http://www.nhlbi.nih.gov/guidelines/asthma/>.

**1c.8 Net Benefit** (*Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms*):

Our measure will help to improve the quality of asthma care by ensuring that patients have access to standard rescue therapy in the event of an acute exacerbation. The use of short acting beta-agonists have been reported to be safe with little or no cardiovascular side effects.

Citation:

1. National Asthma Education and Prevention Program. Expert Panel Report 3: Guidelines for the diagnosis and management of asthma. Pg.236 . Bethesda, MD: National Heart, Lung, and Blood Institute, National Institutes of Health. 2007. Available from: <http://www.nhlbi.nih.gov/guidelines/asthma/>.

**1c.9 Grading of Strength/Quality of the Body of Evidence.** Has the body of evidence been graded? **No**

**1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:** **There was no grade for this body of evidence.**

**1c.11 System Used for Grading the Body of Evidence:** **Other**

**1c.12 If other, identify and describe the grading scale with definitions:** **There was no grade for this body of evidence.**

**1c.13 Grade Assigned to the Body of Evidence:** **There was no grade for this body of evidence.**

**1c.14 Summary of Controversy/Contradictory Evidence:** There is no controversy with respect to short-acting beta-agonists as they are the mainstay of treatment for acute symptoms of bronchospasm. This is true both in routine outpatient management of persons who have asthma and for their treatment in the clinic or ED. The main short-acting beta-agonists in use today are effective agonists and have few negative cardiovascular effects.

**1c.15 Citations for Evidence other than Guidelines(*Guidelines addressed below*):**

1. National Asthma Education and Prevention Program. Expert Panel Report 3: Guidelines for the diagnosis and management of asthma. NIH pub no 07-4051. Bethesda, MD: National Heart, Lung, and Blood Institute, National Institutes of Health. 2007. Available from: <http://www.nhlbi.nih.gov/guidelines/asthma/>.

**1c.16 Quote verbatim, the specific guideline recommendation** (*Including guideline # and/or page #*):

The use of SABA is the most effective medication for relieving acute bronchoconstriction. SABAs have few negative cardiovascular effects.

**1c.17 Clinical Practice Guideline Citation:** National Asthma Education and Prevention Program. Expert Panel Report 3: Guidelines for the diagnosis and management of asthma. Pg.236 . Bethesda, MD: National Heart, Lung, and Blood Institute, National Institutes of Health. 2007. Available from: <http://www.nhlbi.nih.gov/guidelines/asthma/>.

**1c.18 National Guideline Clearinghouse or other URL:** <http://www.nhlbi.nih.gov/guidelines/asthma/>

**1c.19 Grading of Strength of Guideline Recommendation.** Has the recommendation been graded? **Yes**

**1c.20 If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:** **National Asthma Education and**

Prevention Program Coordinating Committee, coordinated by the National Heart, Lung, and Blood Institute of the National Institutes of Health. Any financial and nonfinancial conflicts of interest of the group members were declared, discussed, and resolved.

**1c.21 System Used for Grading the Strength of Guideline Recommendation:** Other

**1c.22 If other, identify and describe the grading scale with definitions:** Evidence Category A:

Randomized controlled trials (RCTs), rich body of data.

Evidence is from end points of well-designed RCTs that provide a consistent pattern of findings in the population for which the recommendation is made. Category A requires substantial numbers of studies involving substantial numbers of participants.

Evidence Category B: RCTs, limited body of data. Evidence is from end points of intervention studies that include only a limited number of patients, post hoc or subgroup analysis of RCTs, or meta-analysis of RCTs. In general, category B pertains when few randomized trials exist; they are small in size, they were undertaken in a population that differs from the target population of the recommendation, or the results are somewhat inconsistent.

Evidence Category C: Nonrandomized trials and observational studies. Evidence is from outcomes of uncontrolled or nonrandomized trials or from observational studies.

Evidence Category D: Panel consensus judgment. This category is used only in cases where the provision of some guidance was deemed valuable, but the clinical literature addressing the subject was insufficient to justify placement in one of the other categories. The Panel consensus is based on clinical experience or knowledge that does not meet the criteria for categories A through C.

Citation:

National Asthma Education and Prevention Program. Expert Panel Report 3: Guidelines for the diagnosis and management of asthma. Pg.7 . Bethesda, MD: National Heart, Lung, and Blood Institute, National Institutes of Health. 2007. Available from: <http://www.nhlbi.nih.gov/guidelines/asthma/>.

**1c.23 Grade Assigned to the Recommendation:** Evidence Category A: Randomized controlled trials (RCTs), rich body of data.

**1c.24 Rationale for Using this Guideline Over Others:** The Expert Panel Report 3 (EPR-3) Full Report 2007: Guidelines for the Diagnosis and Management of Asthma was developed by an expert panel commissioned by the National Asthma Education and Prevention Program (NAEPP) Coordinating Committee (CC), coordinated by the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health. These are nationally recognized guidelines for the management of asthma.

**Based on the NQF descriptions for rating the evidence, what was the developer's assessment of the quantity, quality, and consistency of the body of evidence?**

1c.25 Quantity: Moderate 1c.26 Quality: Moderate 1c.27 Consistency: Moderate

1c.28 Attach evidence submission form:

1c.29 Attach appendix for supplemental materials:

**Was the threshold criterion, *Importance to Measure and Report*, met?**

**(1a & 1b must be rated moderate or high and 1c yes) Yes ☐ No ☒**

**Provide rationale based on specific subcriteria:**

**For a new measure if the Committee votes NO, then STOP.**

**For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.**

## 2. RELIABILITY & 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. **(evaluation criteria)**

Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See [guidance on measure testing](#).

**S.1 Measure Web Page** (*In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained*). Do you have a web page where current detailed specifications for this measure can be obtained? **Yes**

**S.2 If yes, provide web page URL:** [www.activehealth.com/nqf-measures-with-articles](http://www.activehealth.com/nqf-measures-with-articles)

### 2a. RELIABILITY. Precise Specifications and Reliability Testing: **H M L I**

#### 2a1. Precise Measure Specifications. (*The measure specifications precise and unambiguous.*)

**2a1.1 Numerator Statement** (*Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome*):

**Patients who have at least one refill for a short acting beta agonist for rescue therapy in the past 12 months.**

**2a1.2 Numerator Time Window** (*The time period in which the target process, condition, event, or outcome is eligible for inclusion*):

**12 months.**

**2a1.3 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, codes with descriptors, and/or specific data collection items/responses*):

**(NOTE: Words written in capital letters are element names. Please refer to the code set for description.)**

One of the following:

1. Presence of at least 1 refill for a B-AGONIST (SHORT ACTING-INHALED) in the past 12 months.
2. Presence of patient data confirming the refill for a B-AGONIST (SHORT ACTING-INHALED) in the past 12 months.

**2a1.4 Denominator Statement** (*Brief, narrative description of the target population being measured*):

**Patients 2 years and older with a diagnosis of asthma who had at least one office visit in the past 12 months.**

**2a1.5 Target Population Category** (*Check all the populations for which the measure is specified and tested if any*): **Children, Populations at Risk**

**2a1.6 Denominator Time Window** (*The time period in which cases are eligible for inclusion*):

**12 months.**

**2a1.7 Denominator Details** (*All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses*):

**(NOTE: Words written in capital letters are element names. Please refer to the code set for description.)**

All of the following:

1. Patient age greater than or equal to 2 years.

2. One of the following
  - a. Presence of Health Information Exchange data indicating ASTHMA diagnosis in the past 12 months
  - b. Presence of 2 ASTHMA diagnoses in the past 24 months.
  - c. Presence of patient data confirming at least 1 ASTHMA diagnosis in the past 12 months.
3. One of the following:
  - a. Presence of at least 1 ASTHMA diagnosis overlapping within 3 days with an OFFICE VISIT procedure in the past 12 months.
  - b. Presence of at least 2 refills for ASTHMA MEDS (W/O SHORT ACTING BETA AGONISTS) in the past 12 months.
  - c. Presence of patient data confirming at least 1 refill for ASTHMA MEDS (W/O SHORT ACTING BETA AGONISTS) in the past 12 months.

**2a1.8 Denominator Exclusions** *(Brief narrative description of exclusions from the target population):*

- 1.General exclusion for Terminal Illness
- 2.General exclusion for cancer
- 3.Provider or patient feedback stating patient does not have a diagnosis of asthma

**2a1.9 Denominator Exclusion Details** *(All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses):*

(NOTE: Words written in capital letters are element names. Please refer to the code set for description.)

**Specific Exclusions:**

1. Patient or provider feedback indicating allergy or intolerance to the drug in the past.
2. Patient or provider feedback indicating that there is a contraindication to adding the drug
3. Provider or patient feedback stating patient does not have a diagnosis of asthma

**General Exclusions:**

1. Patients who have been in a skilled nursing facility in the last 3 months or who are terminally ill.

**2a1.10 Stratification Details/Variables** *(All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses ):*

This specific measure addresses all asthmatics, regardless of severity of the disease, across the entire measured population. Using our highly specific rule algorithms, people with a confirmed diagnosis of asthma will be included in the denominator. Therefore, no risk adjustment or risk stratification is necessary for this unique measure.

**2a1.11 Risk Adjustment Type** *(Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13):* No risk adjustment or risk stratification **2a1.12 If "Other," please describe:**

**2a1.13 Statistical Risk Model and Variables** *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.):*

This specific measure addresses all asthmatics, regardless of severity of the disease, across the entire measured population. Using our highly specific rule algorithms, people with a confirmed diagnosis of asthma will be included in the denominator. Therefore, no risk adjustment or risk stratification is necessary for this unique measure.

**2a1.14-16 Detailed Risk Model Available at Web page URL** (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach

documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL. Please supply login/password if needed:

**2a1.17-18. Type of Score:** [Rate/proportion](#)

**2a1.19 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](#)

**2a1.20 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.*):  
[Calculation algorithm is included in the attachment for section 2a1.21.](#)

**2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:**  
[Attachment](#)  
[NQF MEASURE 0620 RULES.pdf](#)

**2a1.24 Sampling (Survey) Methodology.** If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):  
[This measure does not require a sampling or a survey.](#)

**2a1.25 Data Source** (*Check all the sources for which the measure is specified and tested*). If other, please describe:  
[Claims, Electronic Health Data, Electronic Health Records, Instrument-Based Data, Other](#)

**2a1.26 Data Source/Data Collection Instrument** (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*): [Our data is collected from a number of electronic sources, e.g. health plans, pharmacy-based management systems, electronic health records, etc. Data may be collected in various forms. We accept claims from pharmacies, labs, third-party payors, hospitals, physicians, etc. Patient-derived data is gathered by our nurses, lifestyle coaches, and nutritionists through our disease management program \(Active DM\), lifestyle coaching program \(ALC\), and maternity program \(MATE\), as well as through our electronic patient health record \(PHR\). Data may also be entered by clinicians and their extenders through our online physician portal \(Active Care Team Suite\).](#)

**2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment:** [URL](#)  
<https://www.activehealthphrpp.net/PortalDemo/PortalLogin.aspx>  
 Username: PHRDemo181 ; Password: Testing456

**2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:**  
[Attachment](#)  
[NQF Measure 0620 Codes.pdf](#)

**2a1.33 Level of Analysis** (*Check the levels of analysis for which the measure is specified and tested*):  
[Clinician : Group/Practice, Clinician : Individual, Facility, Health Plan, Integrated Delivery System, Other, Population : Community, County or City, Population : Regional and State](#)

**2a1.34-35 Care Setting** (Check all the settings for which the measure is specified and tested): **Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Home Care, Inpatient/Hospital**

**2a2. Reliability Testing.** (Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability.)

**2a2.1 Data/Sample** (Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):

All the data for the measures are obtained from electronic sources. Based on the client, we take in administrative claims data, pharmacy-based management systems, laboratory systems, personal health records, health risk assessments, and electronic health records. In addition, we can take in data from care management systems. All data feeds are electronic and do not require manual medical chart abstraction.

We have over 20 million patient records in our database, consisting of data from provider organizations, hospital systems, healthcare plans, Medicare and Medicaid. The average age of the population is 37 years(range 12 – 77) and 51% of the population is female. We tested the reliability of the data on a population of 279,666 patients from a major health plan. The average age of the population was 35 years and 52% were female. The data abstraction was performed in 2011.

**2a2.2 Analytic Method** (Describe method of reliability testing & rationale):

All of our quality measures are electronic and all of the data used to support the measures are electronic. In addition, we receive the data by electronic feeds. We have internal processes to ensure that we receive valid codes and where appropriate the associated values. Our analytic process includes testing a new rule or algorithm on our test database of 2 million patient records, so that we can be sure of the reliability of the code. At the end of the test, we randomly select patients who are either in the numerator, or in the denominator but not the numerator, to ensure that they met the requirements of the rule. As a part of our reliability testing, we check to ensure that we have found the correct people in the denominator or the numerator, across multiple rules with similar definitions. To ensure accuracy, we check a subset of the people who were not in the numerator to ensure that we were accurate in not counting them in the numerator. If we find errors at any stage of the reliability testing, e.g., similar denominators that had significant differences in counts, different compliance rates for similar populations; we update the rules and retest.

**2a2.3 Testing Results** (Reliability statistics, assessment of adequacy in the context of norms for the test conducted):

Below are the descriptive statistics for the data sources of the test population:

1. The proportion of patients within each client group with diagnosis/procedure claims in the last 365 days was: median 53% (IQR = 10%).
2. The proportion of patients within each client group with at least 1 prescription in the last 365 days was: median 81% (IQR = 8%).
3. The proportion of patients within each client group with lab results in the last 365 days was: median 46% (IQR = 12%).

**2b. VALIDITY. Validity, Testing, including all Threats to Validity:** **H● M● L● I●**

**2b1.1 Describe how the measure specifications (measure focus, target population, and exclusions) are consistent with the evidence cited in support of the measure focus (criterion 1c) and identify any differences from the evidence:**

Rescue therapy with short acting beta-agonist therapy is a part of the cornerstone of medical management of asthma. Our measure focuses on the availability of short acting beta-agonists in asthmatic patients. There are no exclusions for this measure. The availability of rescue therapy for asthmatics should help to decrease emergency room and hospital visits. Our measure provides indirect evidence of a performance

gap.

**2b2. Validity Testing.** *(Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.)*

**2b2.1 Data/Sample** *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):*

All the data for the measures are obtained from electronic sources. Based on the client, we take in administrative claims data, pharmacy-based management systems, laboratory systems, personal health records, health risk assessments, and electronic health records. In addition, we can take in data from care management systems. All data feeds are electronic and do not require manual medical chart abstraction.

We have over 20 million patient records in our database, consisting of data from provider organizations, hospital systems, healthcare plans, Medicare and Medicaid. The average age of the population is 37 years (range 12 – 77) and 51% of the population is female. We tested the validity of the data on a population of 279,666 patients from a major health plan. The average age of the population was 35 years and 52% were female. The data abstraction was performed in 2011.

**2b2.2 Analytic Method** *(Describe method of validity testing and rationale; if face validity, describe systematic assessment):*

All of our quality measures are electronic and all the data used to support the measures are electronic. In addition, we receive the data by electronic feeds. We have internal processes to ensure that we receive valid codes and where appropriate the associated values. Currently we use a database of approximately 2 million patient records for testing purposes. Our analytic process includes testing a new rule or algorithm on the standard data set so that we can be sure of the reliability of the code. At the end of the test, we randomly select patients who are either in the numerator, or in the denominator but not the numerator, to ensure that they met the requirements of the rule. As a part of our validity testing, we check to ensure we have found the correct people in the denominator or the numerator. To ensure accuracy, we check a subset of the people who were not in the numerator to ensure that we were accurate in not counting them in the numerator. If we find errors at any stage of the reliability testing, e.g., similar denominators that had differences in counts, compliance rates for similar populations that differ, then we update the rules and retest.

Further, to ensure that we obtain valid results once the measures are deployed, when we run the measure for a client we evaluate the results to ensure they are consistent with what we have found in the past for the client and across our book of business.

This year, we added ICD 10 codes to our already robust code sets. A team of analysts performed a concise mapping of ICD 9 codes to their respective ICD 10 codes. A group of clinicians from the Clinical Research and Development team reviewed the results of this mapping for accuracy. The ICD 10 code sets were emailed to the NQF Measures Maintenance Director, Glyndon Morris, on February 24, 2012 separately from our traditional code sets (which were uploaded in Section 2a 1.30)

**2b2.3 Testing Results** *(Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment):*

The algorithms and code sets used for the measures are all electronic. Once we test the rules, the results are reviewed by our clinical research and development committee, composed of physicians of varying specialties, pharmacists, and nurses. After the rules are deployed in a production environment for our clients, the rule is considered reliable, i.e., we have found the appropriate people in the denominator and numerator.

**POTENTIAL THREATS TO VALIDITY.** *(All potential threats to validity were appropriately tested with adequate results.)*

**2b3. Measure Exclusions.** *(Exclusions were supported by the clinical evidence in 1c or appropriately tested with results demonstrating the need to specify them.)*

**2b3.1 Data/Sample for analysis of exclusions** *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):*

All the data for the measures are obtained from electronic sources. Based on the client, we take in administrative claims data, pharmacy-based management systems, laboratory systems, personal health records, health risk assessments, and electronic health records. In addition, we can take in data from care management systems. All data feeds are electronic and do not require manual medical chart abstraction.

We have over 20 million patient records in our database, consisting of data from provider organizations, hospital systems, healthcare plans, Medicare and Medicaid. The average age of the population is 37 years (range 12 – 77) and 51% of the population is female. We tested the exclusion criteria of the measure on a population of 279,666 patients from a major health plan. The average age of the population was 35 years and 52% were female. The data abstraction was performed in 2011.

**2b3.2 Analytic Method** *(Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference):*

We exclude those patients are terminally ill. Our exclusions are tested and analyzed using the same methodology as for our numerator and denominator.

**2b3.3 Results** *(Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):*

We do not perform statistical analysis for our exclusions. We manually review our electronic processes to ensure accuracy of our exclusions.

**2b4. Risk Adjustment Strategy.** *(For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.)*

**2b4.1 Data/Sample** *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):*

This specific measure addresses all asthmatics, regardless of severity of the disease, across the entire measured population. Using our highly specific rule algorithms, people with a confirmed diagnosis of asthma will be included in the denominator. Therefore, no risk adjustment or risk stratification is necessary for this unique measure.

**2b4.2 Analytic Method** *(Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables):*

This specific measure addresses all asthmatics, regardless of severity of the disease, across the entire measured population. Using our highly specific rule algorithms, people with a confirmed diagnosis of asthma will be included in the denominator. Therefore, no risk adjustment or risk stratification is necessary for this unique measure.

**2b4.3 Testing Results** *(Statistical risk model: Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata):*

This specific measure addresses all asthmatics, regardless of severity of the disease, across the entire measured population. Using our highly specific rule algorithms, people with a confirmed diagnosis of asthma will be included in the denominator. Therefore, no risk adjustment or risk stratification is necessary for this unique measure.

**2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment:** This specific measure addresses all asthmatics, regardless of severity of the disease, across the entire measured population. Using our highly specific rule algorithms, people with a

confirmed diagnosis of asthma will be included in the denominator. Therefore, no risk adjustment or risk stratification is necessary for this unique measure.

**2b5. Identification of Meaningful Differences in Performance.** *(The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.)*

**2b5.1 Data/Sample** *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):*

We have over 20 million patient records in our database, consisting of data from provider organizations, hospital systems, healthcare plans, Medicare and Medicaid. The average age of the population is 37 years (range 12 – 77) and 51% of the population is female. Of these, 389,540 patients fulfilled the denominator criteria, and the compliance rate was 58%. Data abstraction was performed in 2011.

**2b5.2 Analytic Method** *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance):*

Our ability to analyze measures across different populations is limited by the characteristics of a specific client population. Since the rules are electronic, they are applied consistently, independent of the population characteristics. For example running this measure on a young population, may result in a lower denominator and compliance rate, compared to evaluating the measure across an older population.

All of our quality measures are electronic and all the data used to support the measures are electronic. In addition, we receive the data by electronic feeds. We have internal processes to ensure that we receive valid codes and where appropriate the associated values. Our analytic process includes testing a new rule or algorithm on our test database of 2 million patient records, so that we can be sure of the reliability of the code. At the end of the test, we randomly select patients who are either in the numerator, or in the denominator but not the numerator, to ensure that they met the requirements of the rule. As a part of our reliability testing, we check to ensure we have found the correct people in the denominator or the numerator, across multiple rules with similar definitions. To ensure accuracy, we check a subset of the people who were not in the numerator to ensure that we were accurate in not counting them in the numerator. If we find errors at any stage of the reliability testing, e.g., similar denominators that had significant differences in counts, different compliance rates for similar populations; we update the rules and retest.

**2b5.3 Results** *(Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningful differences in performance):*

Measure performance results across 106 client populations for this measure (N = 389,540):

10th percentile = 48%  
 25th percentile = 56%  
 50th percentile = 59%  
 75th percentile = 65%  
 90th percentile = 100%

Interquartile range = 9%

**2b6. Comparability of Multiple Data Sources/Methods.** *(If specified for more than one data source, the various approaches result in comparable scores.)*

**2b6.1 Data/Sample** *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):*

We receive electronic data from multiple sources – health plan, electronic health record, personal health record, etc. Independent of the sources, all the available data about a patient are aggregated into a single patient record for use in performance measurement. Therefore, for an individual patient the record will include claims data, clinical data from an electronic health record, or a self-reported data from a patient

health record. Based on this, we do not typically conduct analyses based on disparate sources of data. Instead, the rules contain redundancies to accommodate the different sources of data or the absence of specific data based on the source. Therefore, this measure has not been compared across data sources.

**2b6.2 Analytic Method** (Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure):

We ingest data from multiple sources (e.g., diagnosis, procedure, lab, pharmacy claims, clinical data, patient derived data, provider feedback). Using a complex and highly specific rule algorithm, we are able to ensure that the various data sources are appropriately weighted, based on the consensus of our clinical research and development committee. Therefore, this measure has not been compared across data sources.

**2b6.3 Testing Results** (Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted):

This measure has not been compared across data sources.

**2c. Disparities in Care:** H ☐ M ☐ L ☐ I ☐ NA ☐ (If applicable, the measure specifications allow identification of disparities.)

**2c.1 If measure is stratified for disparities, provide stratified results** (Scores by stratified categories/cohorts): This measure applies to all patients with asthma and is not stratified for disparities.

**2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:**

This measure applies to all patients with asthma and is not stratified for disparities.

**2.1-2.3 Supplemental Testing Methodology Information:**

**Steering Committee: Overall, was the criterion, Scientific Acceptability of Measure Properties, met?** (Reliability and Validity must be rated moderate or high) Yes ☐ No ☐

Provide rationale based on specific subcriteria:

**If the Committee votes No, STOP**

### 3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (**evaluation criteria**)

**C.1 Intended Actual/Planned Use** (Check all the planned uses for which the measure is intended): Public Reporting, Quality Improvement (Internal to the specific organization)

**3.1 Current Use** (Check all that apply; for any that are checked, provide the specific program information in the following questions): Public Reporting, Quality Improvement (Internal to the specific organization)

**3a. Usefulness for Public Reporting:** H ☐ M ☐ L ☐ I ☐

(The measure is meaningful, understandable and useful for public reporting.)

**3a.1. Use in Public Reporting - disclosure of performance results to the public at large** (If used in a public reporting program, provide name of program(s), locations, Web page URL(s)). If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential

reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: **[For Maintenance – If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.]**

Our measure specifications including numerator, denominator, and exclusion descriptions, algorithms, and code sets will be publicly available at the following URL address: [www.activehealth.com/nqf-measures-with-articles](http://www.activehealth.com/nqf-measures-with-articles) ; Username: activehealth ; Password: AH\$1@2

The results of each measure are client specific. Due to the private nature of these results, we leave it to each client's individual discretion to release their results publicly.

**3a.2. Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting.** If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results: [Short acting beta-agonist inhalers area part of standard medical therapy for asthma](#). The evidence based literature with respect to asthma is limited to preventative therapy asthma with inhaled corticosteroids, long-acting beta-agonists, leukotriene modifiers or immunomodulator therapy. There is also literature on short-acting beta-agonist overuse which indirectly assesses the level of asthma control. Our data analysis of 389,540 patients revealed that 42 percent of asthmatics did not have short acting rescue therapy available in a 12 month period. Our data indicates that there is indeed a performance gap. Improvement in performance for this measure should decrease emergency room and hospital visits.

**3.2 Use for other Accountability Functions (payment, certification, accreditation).** If used in a public accountability program, provide name of program(s), locations, Web page URL(s): [We do not use our measures for other accountability functions at this time.](#)

### **3b. Usefulness for Quality Improvement: H● M● L● I●**

*(The measure is meaningful, understandable and useful for quality improvement.)*

**3b.1. Use in QI.** If used in quality improvement program, provide name of program(s), locations, Web page URL(s):

**[For Maintenance – If not used for QI, indicate the reasons and describe progress toward using performance results for improvement].**

This measure is used in quality improvement programs internal to a specific organization, e.g., our individual clients.

**3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement.** If usefulness was demonstrated (e.g., QI initiative), describe the data, method and results:

[Short acting beta-agonist inhalers area part of standard medical therapy for asthma](#). The evidence based literature with respect to asthma is limited to preventative therapy asthma with inhaled corticosteroids, long-acting beta-agonists, leukotriene modifiers or immunomodulator therapy. There is also literature on short-acting beta-agonist overuse which indirectly assesses the level of asthma control. Our data analysis of 389,540 patients revealed that 42 percent of asthmatics did not have short acting rescue therapy available in a 12 month period. Our data indicates that there is indeed a performance gap. Improvement in performance for this measure should decrease emergency room and hospital visits.

**Overall, to what extent was the criterion, Usability, met? H● M● L● I●**  
Provide rationale based on specific subcriteria:

## **4. FEASIBILITY**

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

implemented for performance measurement. (**evaluation criteria**)

**4a. Data Generated as a Byproduct of Care Processes: H ☐ M ☒ L ☐ I ☐**

**4a.1-2 How are the data elements needed to compute measure scores generated?** (*Check all that apply*).

Data used in the measure are:

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Other

We are also able to ingest and process patient derived data, data from our disease management programs, and provider feedback.

**4b. Electronic Sources: H ☐ M ☒ L ☐ I ☐**

**4b.1 Are the data elements needed for the measure as specified available electronically** (*Elements that are needed to compute measure scores are in defined, computer-readable fields*): ALL data elements are in a combination of electronic sources

**4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources:**

**4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences: H ☐ M ☒ L ☐ I ☐**

**4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:**

We use a combination of data sources to mitigate the risk of inaccuracies or errors. We recognize that generally, electronic data have inherent errors and inaccuracies related to incorrect coding, or missing data, which can result in less specificity in the definition of the denominator and /or the numerator. To minimize these errors and inaccuracies, we use clinically enriched data (laboratory results, medication lists) to augment the data. In addition, where possible, we corroborate the data. For example, to confirm a patient has diabetes, we not only confirm the presence of an ICD-9 code for diabetes from claims, we also substantiate this finding with the presence of diabetic medications. We have a mechanism in place to solicit feedback from providers via a feedback form, if they detect errors with the measure.

We do not anticipate significant unintended consequences from the implementation of this measure. Our measures are all developed from evidence-based literature or from clinical practice guidelines and are designed to encourage appropriate care of the patient.

**4d. Data Collection Strategy/Implementation: H ☐ M ☒ L ☐ I ☐**

**A.2 Please check if either of the following apply** (*regarding proprietary measures*): Proprietary measure

**4d.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** (*e.g., fees for use of proprietary measures*):

Providers prefer to have a mechanism to provide feedback, and that our algorithms minimize the risk of false positives. Consequently, we allow the ingest of provider feedback in our rule algorithms, which err on the side of specificity. We have also learned that we have to be flexible to take in data from all available sources.

**Overall, to what extent was the criterion, *Feasibility*, met? H ☐ M ☒ L ☐ I ☐**  
Provide rationale based on specific subcriteria:

**OVERALL SUITABILITY FOR ENDORSEMENT**

**Does the measure meet all the NQF criteria for endorsement? Yes ☐ No ☒**

**Rationale:**

**If the Committee votes No, STOP.**

**If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.**

## 5. COMPARISON TO RELATED AND COMPETING MEASURES

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure before a final recommendation is made.

**5.1 If there are related measures (either same measure focus or target population) or competing measures (both the same measure focus and same target population), list the NQF # and title of all related and/or competing measures:**

0548 : Suboptimal Asthma Control (SAC) and Absence of Controller Therapy (ACT)

### 5a. Harmonization

**5a.1 If this measure has EITHER the same measure focus OR the same target population as [NQF-endorsed measure\(s\)](#): Are the measure specifications completely harmonized? No**

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

Although this measure has the same target population, it does not have the same measure focus. While measure 0548 identifies patient overuse of short-acting inhalers (>5 canisters/year), our measure focuses on ensuring that patients have AT LEAST 1 rescue inhaler (short-acting) for their asthma symptoms, with the goal of reducing over-utilization of costly resources (e.g., hospital, emergency department or urgent care visits) due to a mere lack of not having a rescue inhaler handy.

### 5b. Competing Measure(s)

**5b.1 If this measure has 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 both the same target population and the same measure focus as any other NQF-endorsed measure.

## CONTACT INFORMATION

**Co.1 Measure Steward (Intellectual Property Owner):** [ActiveHealth Management, 1333 Broadway, 4th Floor, New York, New Mexico, 10018](#)

**Co.2 Point of Contact:** [Madhavi, Vemireddy, MD, mvemireddy@activehealth.net, 212-651-8200-](#)

**Co.3 Measure Developer if different from Measure Steward:** [ActiveHealth Management, 1333 Broadway, 4th Floor, New York, New York, 10018](#)

**Co.4 Point of Contact:** [Rajesh, Mehta, R.Ph., MS., rmehta@activehealth.net, 212-651-8200-](#)

**Co.5 Submitter:** [Rajesh, Mehta, R.Ph., MS., rmehta@activehealth.net, 212-651-8200-, ActiveHealth](#)

Management

**Co.6 Additional organizations that sponsored/participated in measure development:**

**Co.7 Public Contact:** [Rajesh, Mehta, R.Ph., MS., rmehta@activehealth.net, 212-651-8200-, ActiveHealth Management](#)

**ADDITIONAL INFORMATION**

**Workgroup/Expert Panel involved in measure development**

**Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.**

[Bani Vir, MD: Medical Director, Clinical Research & Development, ActiveHealth Management, Inc.](#)  
[Lindee Chin, MD: Medical Director, Clinical Research & Development, ActiveHealth Management, Inc.](#)  
[Ajay Sharma, MD: Medical Director, Clinical Research & Development, ActiveHealth Management, Inc.](#)  
[George Wu, MD: Medical Director, Clinical Research & Development, ActiveHealth Management, Inc.](#)  
[Flora Chang, PharmD, Director of Pharmacy Informatics, Clinical Research & Development, ActiveHealth Management.](#)  
[Rajesh R. Mehta, R.Ph., MS, Director of Pharmacy Informatics, Clinical Research & Development, ActiveHealth Management.](#)

[ActiveHealth Management measures are developed by our Quality Measures Management Committee, a division of the Clinical Research and Development Department, composed of physicians of varying specialties and pharmacists. This committee evaluates available clinical evidence guidelines, reliability of data from various sources, and the necessity to develop measures to help improve standards of healthcare.](#)

**Ad.2 If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward:**

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

**Ad.3 Year the measure was first released:** [2007](#)

**Ad.4 Month and Year of most recent revision:** [12, 2011](#)

**Ad.5 What is your frequency for review/update of this measure?** [Annual](#)

**Ad.6 When is the next scheduled review/update for this measure?** [12, 2012](#)

**Ad.7 Copyright statement:** [This information, including any attachments hereto, is the sole, exclusive, proprietary and confidential property of ActiveHealth Management, Inc., and is for the exclusive use of The National Quality Forum. Any use, copying, disclosure, dissemination or distribution by anyone other than the National Quality Forum is strictly prohibited.](#)

**Ad.8 Disclaimers:**

**Ad.9 Additional Information/Comments:** [Username and Password for the URL listed in "Specifications" section of this submission:](#)

[URL: www.activehealth.com/nqf-measures-with-articles](#)

[Username: activehealth](#)

[Password: AH\\$1@2](#)

**Date of Submission (MM/DD/YY):** [10/18/2011](#)