



## 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 #: 0629**

**Corresponding Measures:**

**De.2. Measure Title:** Male Smokers or Family History of Abdominal Aortic Aneurysm (AAA) - Screening for AAA

**Co.1.1. Measure Steward:** ActiveHealth Management

**De.3. Brief Description of Measure:** The percentage of men aged 65 through 75 with history of tobacco use or men aged 60 years or more with a family history of abdominal aortic aneurysm (AAA) who were screened for AAA

**1b.1. Developer Rationale:** On the basis of our systematic review and meta-analyses, an invitation to attend AAA screening may reduce AAA-related mortality by 43% in men age 65 to 75 years. The Western Australia screening study also included patients 75 to 83 years of age. In a post hoc analysis, a significant reduction of AAA-related mortality from screening was seen in men 65 to 74 years of age but not in older men. The absolute risk reduction for AAA-related deaths over 4 to 5 years ranged from 3.6 per 10,000 in the Western Australia trial to 21 per 10,000 in the Chichester and Viborg County trials. It is important to note that these estimates pertain to screening in populations and not to screening for individuals.

After adjustment for other risk factors, a history of smoking is associated with a 5-fold increase in AAA risk (1). Using a model of AAA screening in 65- to 74-year-old men, we estimated that 89% of AAA-related deaths prevented would be attributable to screening in 69% of those men with any history of smoking during their lifetime. Neither a current history of smoking nor consideration of other AAA risk factors appears to be more accurate than age, sex, and lifetime smoking history in selecting a high-risk screening population.

- Reference: Fleming C, Whitlock EP, Beil TL, et al. Screening for abdominal aortic aneurysm: a best-evidence systematic review for the U.S. Preventive Services Task Force. Ann Intern Med. 2005;142:203–11.

**S.4. Numerator Statement:** Men who have had AAA screening anytime in the past

**S.7. Denominator Statement:** Men aged 65 through 75 years with a history of tobacco use anytime in the past, or men aged 60 years and older with a family history of abdominal aortic aneurysm

**S.10. Denominator Exclusions:** General exclusions:

1. Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months;
2. Patients who have been in a skilled nursing facility in the last 3 months
3. Patients who are terminally ill or in Hospice

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

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

**S.26. Level of Analysis:** Health Plan, Other, Population : Regional and State

**IF Endorsement Maintenance – Original Endorsement Date:** Dec 04, 2009 **Most Recent Endorsement Date:** May 02, 2012

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

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

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

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

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

### 1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form 0629\_Evidence\_MSF5.0\_Data-635278487390198972.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)

On the basis of our systematic review and meta-analyses, an invitation to attend AAA screening may reduce AAA-related mortality by 43% in men age 65 to 75 years. The Western Australia screening study also included patients 75 to 83 years of age. In a post hoc analysis, a significant reduction of AAA-related mortality from screening was seen in men 65 to 74 years of age but not in older men. The absolute risk reduction for AAA-related deaths over 4 to 5 years ranged from 3.6 per 10,000 in the Western Australia trial to 21 per 10,000 in the Chichester and Viborg County trials. It is important to note that these estimates pertain to screening in populations and not to screening for individuals.

After adjustment for other risk factors, a history of smoking is associated with a 5-fold increase in AAA risk (1). Using a model of AAA screening in 65- to 74-year-old men, we estimated that 89% of AAA-related deaths prevented would be attributable to screening in 69% of those men with any history of smoking during their lifetime. Neither a current history of smoking nor consideration of other AAA risk factors appears to be more accurate than age, sex, and lifetime smoking history in selecting a high-risk screening population.

- Reference: Fleming C, Whitlock EP, Beil TL, et al. Screening for abdominal aortic aneurysm: a best-evidence systematic review for the U.S. Preventive Services Task Force. *Ann Intern Med.* 2005;142:203–11.

#### 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.

By definition, an AAA is present when the infrarenal aortic diameter exceeds 3.0 cm.<sup>5</sup> Large AAAs are associated with approximately 9,000 deaths annually in the United States.<sup>6</sup> The prevalence of AAAs found in population-based ultrasonography screening studies from various countries is about 4 percent to 9 percent in men and 1 percent in women.<sup>7-12</sup> The prevalence of an AAA greater than 5.0 cm in men aged 50 to 79 is estimated to be 0.5 percent.<sup>13</sup> Almost all deaths from ruptured AAAs occur in men older than 65; most AAA-related deaths occur in men younger than 80; and most AAA-related deaths in women occur when they are older than 80.<sup>14,15</sup>

The USPSTF found good evidence that screening for AAA and surgical repair of large AAAs (5.5 cm or more) in men aged 65 to 75 who have ever smoked (current and former smokers) leads to decreased AAA-specific mortality. There is good evidence that abdominal ultrasonography, performed in a setting with adequate quality assurance (i.e., in an accredited facility with credentialed technologists), is an accurate screening test for AAA.

Based on our search for performance results on this measure, we found that there is a lack of descriptive statistics demonstrating a performance gap for AAA screening with ultrasound in male smokers. However, using our test data, we identified 3563 patients who qualified for AAA screening, out of a total population of nearly 2.5 million lives. Out of those identified for this measure in the test data, only 1774, or 49.8% were screened with appropriate testing. Looking at our total member population, 2753 were identified as being at risk for AAA and lacking evidence of screening with an ultrasound. Even after physicians were alerted to the gap in care, only 466, or 17% of members identified as at risk, received the appropriate screening.

#### 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.

Using our test data, we identified 3563 patients who qualified for AAA screening, out of a total population of nearly 2.5 million lives. Out of those identified for this measure, only 1774, or 49.8% were screened with appropriate testing. Looking at our total member population from January through December of 2010, 2753 people were identified as being at risk for AAA and lacking evidence of screening with an ultrasound. Even after physicians were alerted to the gap in care, only 466, or 17% of members identified as at risk, received the appropriate screening.

The USPSTF review identified four randomized controlled trials (RCTs) of screening for AAA; these RCTs predominantly screened white men aged 65 and older.<sup>2,3</sup> A good-quality RCT of 67,800 white men aged 65 to 74 was conducted to evaluate screening for AAA.<sup>8</sup> Screening was performed by ultrasonography and surgery in men with AAAs greater than 5.4 cm. The study showed AAA related-mortality was reduced by an average of 42 percent (95 percent CI, 22 percent-58 percent) in the screened population compared with the non-screened population; the absolute reduction in AAA-specific mortality was 0.14 percent (0.33 percent in the non-screened group and 0.19 percent in the screened group).

**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.*

The potential benefit of screening for AAA among women aged 65 to 75 is low because of the small number of AAA-related deaths in this population. The majority of deaths from AAA rupture occur in women aged 80 or older. Because there are many competing health risks at this age, any benefit of screening for AAA would be minimal. Individualization of care, however, is still required. For example, a clinician may choose to discuss screening in the unusual circumstance in which a healthy female smoker in her early 70s has a first-degree family history for AAA that required surgery.

The Society for Vascular Surgery and the Society for Vascular Medicine and Biology recommend screening all men aged 60 to 85 for AAA; women aged 60 to 85 with cardiovascular risk factors; and men and women aged 50 and older with a family history of AAA. These groups further recommend the following courses of action after screening: no further testing if aortic diameter is less than 3.0 cm; yearly ultrasonographic screening if aortic diameter is between 3.0 to 4.0 cm; ultrasonography every 6 months if aortic diameter is between 4.0 to 4.5 cm; and referral to a vascular specialist if aortic diameter is greater than 4.5 cm.<sup>34</sup>

Reference: Reference: Fleming C, Whitlock EP, Beil TL, et al. Screening for abdominal aortic aneurysm: a best-evidence systematic review for the U.S. Preventive Services Task Force. *Ann Intern Med.* 2005;142:203–11.

Reference: Kent KC, Zwolak RM, Jaff MR, et al. Screening for abdominal aortic aneurysm: a consensus statement. *J Vasc Surg.* 2004;39:267–9

**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.**

Using our test data, we identified 3563 patients who qualified for AAA screening, out of a total population of nearly 2.5 million lives. Out of those identified for this measure, only 1774, or 49.8% were screened with appropriate testing. Looking at our total member population from January through December of 2010, 2753 people were identified as being at risk for AAA and lacking evidence of screening with an ultrasound. Even after physicians were alerted to the gap in care, only 466, or 17% of members identified as at risk, received the appropriate screening.

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The Chichester trial included 9342 women age 65 to 80 years who were randomly assigned to either an invitation-to-screening group or a control group (Table 1) (20). Sixty-five percent of women attended screening, compared with 73% of men ( $P < 0.001$ ). The AAA prevalence in women was 1.3%, compared with 7.6% in men. At 5 years of follow-up, there were no differences between women invited for screening and the control group in either AAA-related mortality (OR, 1.0 [CI, 0.14 to 7.07]) or all-cause mortality (OR, 1.05 [CI, 0.92 to 1.19]). At 10 years, the incidence of AAA rupture was the same for women in the screening and control groups (9).

Reference: Reference: Fleming C, Whitlock EP, Beil TL, et al. Screening for abdominal aortic aneurysm: a best-evidence systematic review for the U.S. Preventive Services Task Force. *Ann Intern Med.* 2005;142:203–11.

**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**

Severity of illness

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

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

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

Abdominal aortic aneurysms are found in 4% to 8% of older men and 0.5% to 1.5% of older women. Age, smoking, sex, and family history are the most significant AAA risk factors. Aortic aneurysms account for about 15,000 deaths in the United States annually; of these, 9,000 are AAA-related and the remainder are due to thoracic aortic aneurysms. Most AAA deaths occur in men 65 years of age and older

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

- ACCF/AHA/ACR/SCAI/SIR/SVM/SVN/SVS 2010 performance measures for adults with peripheral artery disease: a report of the American College of Cardiology Foundation/American Heart Association Task Force on performance measures, the American College of Radiology, the Society for Cardiac Angiography and Interventions, the Society for Interventional Radiology, the Society for Vascular Medicine, the Society for Vascular Nursing, and the Society for Vascular Surgery (Writing Committee to Develop Clinical Performance Measures for Peripheral Artery Disease). *Circulation.* 2010 Dec 14;122(24):2583-618
- ACC/AHA 2005 Practice Guidelines for the management of patients with peripheral arterial disease (lower extremity, renal, mesenteric, and abdominal aortic): a collaborative report from the American Association for Vascular Surgery/Society for Vascular Surgery, Society for Cardiovascular Angiography and Interventions, Society for Vascular Medicine and Biology, Society of Interventional Radiology, and the ACC/AHA Task Force on Practice Guidelines (Writing Committee to Develop Guidelines for the Management of Patients With Peripheral Arterial Disease): endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation; National Heart, Lung, and Blood Institute; Society for Vascular Nursing; TransAtlantic Inter-Society Consensus; and Vascular Disease Foundation. *Circulation.* 2006 Mar 21;113(11):e463-654.
- Recommendations. U.S. Preventive Services Task Force  
<http://www.uspreventiveservicestaskforce.org/recommendations.htm>
- Fleming C, Whitlock EP, Beil TL, et al. Screening for abdominal aortic aneurysm: a best-evidence systematic review for the U.S. Preventive Services Task Force. *Ann Intern Med.* 2005;142:203–11.
- Kent KC, Zwolak RM, Jaff MR, et al. Screening for abdominal aortic aneurysm: a consensus statement. *J Vasc Surg.* 2004;39:267–9

**1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)**

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

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

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

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

**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.)

<http://www.activehealth.net/nqf-measures.php>

**S.2a. If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

**Attachment:**

**S.2b. Data Dictionary, Code Table, or Value Sets** (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

**Attachment Attachment:** [NQF\\_629\\_CODE\\_SET\\_2013\\_Final.xlsx](#)

**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.

[Men who have had AAA screening anytime in the past](#)

**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.)

[Anytime in the past](#)

**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.

**Numerator:**

1. One of the following:

- a. Presence of patient data via online PHR or telephonic nurse assessment confirming at least 1 PDD-Screening for AAA OBSER anytime in the past
- b. Presence of at least 1 AAA Repair procedure from claims anytime in the past
- c. Presence of at least 1 Abdominal Aortic Aneurysm diagnosis from claims anytime in the past
- d. Presence of At Least 1 Abdominal Imaging procedure from claims anytime in the past
- e. Presence of provider or patient feedback indicating AAA screening was performed anytime in the past

[See attached for code sets](#)

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

Men aged 65 through 75 years with a history of tobacco use anytime in the past, or men aged 60 years and older with a family history of abdominal aortic aneurysm

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

Populations at Risk

**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)

(Words written in all capitals are element names. Please refer to the code set for full description.)

DENOMINATOR:

One of the following:

1. All of the following:

- a. Male patients aged 60 years and older
- b. Presence of patient data via online PHR or telephonic nurse assessment confirming at least 1 PDD- FHx AAA from claims in the past 12 months

2. All of the following:

- a. Male patients aged 65 through 75 years
- b. One of the following is correct:
  - i. Presence of at least 2 SMOKING-CURRENT AND PAST diagnosis from claims anytime in the past
  - ii. Presence of at least 1 SMOKING CESSATION procedure from claims anytime in the past
  - iii. Presence of at least 1 refill SMOKING CESSATION drug from claims anytime in the past
  - iv. Presence of patient data via online PHR or telephonic nurse assessment confirming at least 1 PDD-SMOKER (PAST AND CURRENT) anytime in the past

See attached code sets

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

General exclusions:

- 1. Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months;
- 2. Patients who have been in a skilled nursing facility in the last 3 months
- 3. Patients who are terminally ill or in Hospice

**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)

None

**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)

None

**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)

No risk adjustment necessary.



**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.)

1. Determine denominator population
2. Determine population to be excluded from the denominator
3. Subtract excluded population from the denominator population
4. Determine numerator population
5. Divide numerator by the final denominator calculated in step 3

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

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

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

Measure is not based on a sample.

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

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

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

Required for Composites and PRO-PMs.

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

If other, please describe in S.24.

Other

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

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

Data are collected from a number of electronic sources, e.g., health plans, pharmacy-based management systems, electronic health records, patient health records, etc.

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

**S.26. Level of Analysis** (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)  
Health Plan, Other, Population : Regional and State

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

Other

If other: We do not differentiate between practice settings when testing the measures

**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

0629\_MeasureTesting\_MS5.0\_Data-635278487390198972.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.

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

If other: personal health record, disease management system

#### 3b. Electronic Sources

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

**3b.1. To what extent are the specified data elements available electronically in defined fields?** (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)

Yes

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.**

**3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.**

Attachment:

#### 3c. Data Collection Strategy

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

**3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data**



collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

**IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.**

Generally, we have learned that we have to be flexible to take in data from all possible sources. We have also heard from providers, that they prefer that the rules err on the side of specificity, e.g., lessen the risk of false positives, that is, identifying the wrong patient for the denominator and that they want a mechanism to provide feedback

**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	
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.**

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 if we receive an ICD-9 code for diabetes from claims, we also build include in the rule the requirement for 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 the 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.

## 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.)**

*This measure is not similar to other measures already endorsed by NQF.*

## 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):** ActiveHealth Management

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

**Co.3 Measure Developer if different from Measure Steward:** Active Health Management

**Co.4 Point of Contact:** Lindee, Chin, [Ichin@activehealth.net](mailto:Ichin@activehealth.net), 212-590-2674-

## 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.**

**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:** 12, 2010

**Ad.4 What is your frequency for review/update of this measure?** Every 2 years

**Ad.5 When is the next scheduled review/update for this measure?** 10, 2013

**Ad.6 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.7 Disclaimers:**

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