



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 #: 0650

Corresponding Measures:

De.2. Measure Title: Melanoma: Continuity of Care – Recall System

Co.1.1. Measure Steward: American Academy of Dermatology

De.3. Brief Description of Measure: Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month reporting period, into a recall system that includes:

- A target date for the next complete physical skin exam , AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

1b.1. Developer Rationale: Follow-up for skin examination and surveillance is an important aspect in the management of patients with a current diagnosis or a history of melanoma. The presence of a recall system, whether it is electronic or paper based, enables providers to ensure that patients receive follow-up appointments and annual screening examinations in a timely manner.

Estimates of the overall risk of recurrence in local, cutaneous melanoma vary between 15–35%. Although this risk diminishes with time, melanoma patients have been known to recur even 10–35 years after the initial diagnosis. Physicians have recommended life-long screening because of this persistent risk and the risk of developing second primary tumors.(1)

The primary goal for follow-up of patients with a history of cutaneous melanoma is early detection of surgically resectable recurrent disease and additional primary melanoma.(2)

1. Mooney MM, Mettlin C, Michalek AM, Petrelli NJ, Kraybill WG. Lifelong Screening of Patients with Intermediate-Thickness Cutaneous Melanoma for Asymptomatic Pulmonary Recurrences. A Cost Effective Analysis. Cancer 1997;80:1052-64.

2. Bichakjian CK, Halpern AC, Johnson TM, Foote Hood A, Grichnik JM, Swetter SM, Tsao H, Barbosa VH, Chuang TY, Duvic M, Ho VC, Sober AJ, Beutner KR, Bhushan R, Smith Begolka W. Guidelines of Care for the Management of Primary Cutaneous Melanoma. Journal of the American Academy of Dermatology 2011;65(5):1032-47.

S.4. Numerator Statement: Patients whose information is entered, at least once within a 12 month period, into a recall system that includes:

- A target date for the next complete physical skin exam , AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

S.7. Denominator Statement: All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma

S.10. Denominator Exclusions: The PCPI exception methodology uses three categories of exception reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason.

Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include system reason(s) for not entering patients into a recall system (eg, melanoma being monitored by another physician provider). Where examples of exceptions are included in the measure language, value sets for these examples are developed and are included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates

the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Documentation of system reason(s) for not entering patients into a recall system (eg, melanoma being monitored by another physician provider)

De.1. Measure Type: Structure

S.23. Data Source: Claims, Electronic Health Records, Other, Paper Medical Records, Registry Data

S.26. Level of Analysis: Clinician : Group/Practice, Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: May 05, 2010 **Most Recent Endorsement Date:** Aug 09, 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? This measure is not included in a composite.

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

0650_Evidence_MSF5.0_Data.doc

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)

Follow-up for skin examination and surveillance is an important aspect in the management of patients with a current diagnosis or a history of melanoma. The presence of a recall system, whether it is electronic or paper based, enables providers to ensure that patients receive follow-up appointments and annual screening examinations in a timely manner.

Estimates of the overall risk of recurrence in local, cutaneous melanoma vary between 15–35%. Although this risk diminishes with time, melanoma patients have been known to recur even 10–35 years after the initial diagnosis. Physicians have recommended life-long screening because of this persistent risk and the risk of developing second primary tumors.(1)

The primary goal for follow-up of patients with a history of cutaneous melanoma is early detection of surgically resectable recurrent disease and additional primary melanoma.(2)

1. Mooney MM, Mettlin C, Michalek AM, Petrelli NJ, Kraybill WG. Lifelong Screening of Patients with Intermediate-Thickness Cutaneous Melanoma for Asymptomatic Pulmonary Recurrences. A Cost Effective Analysis. Cancer 1997;80:1052-64.

2. Bichakjian CK, Halpern AC, Johnson TM, Foote Hood A, Grichnik JM, Swetter SM, Tsao H, Barbosa VH, Chuang TY, Duvic M, Ho VC, Sober AJ, Beutner KR, Bhushan R, Smith Begolka W. Guidelines of Care for the Management of Primary Cutaneous Melanoma. Journal of the American Academy of Dermatology 2011;65(5):1032-47.

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.

This measure was included in the CMS Physician Quality Reporting Initiative/System (PQRI/S) in 2009 through 2011 in the claims and registry options for 2009 (in registry only option for 2010 and beyond) as PQRI/S #137 (Melanoma Continuity of Care – Recall System). The number of professionals reporting on this measure in 2009 was approximately 2,196.

The 2009 PQRI/S Performance Rate reveals that there is a gap in care as shown by the following data: 9.19% of patients reported on did not receive the optimal care.

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.

Appendix B. 2009 Physician Quality Reporting System and eRx Experience Report Detailed Tables

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.*

At least two of the reviewed analyses in urban counties showed that the supply of primary care physicians is less closely related to the health of urban African Americans than it is for urban whites or for African Americans in rural areas. This is likely due to the poorer distribution of primary care physicians in more deprived urban areas, with the consequently greater need to seek care in such places as hospital outpatient units and emergency rooms.(1)

Research and public education efforts have focused on melanoma prevention in white populations because of their higher risk of developing melanoma. Improved secondary prevention measures with earlier detection of thin (early-stage) melanoma likely account for the improved survival among whites from 68% in the early 1970s to 92% in recent years. Such advances, however, have not occurred in other racial and ethnic groups in the United States. Emerging data call attention to disparity in melanoma diagnosis and survival in minorities such as Hispanics and blacks. Multiple reports found that US blacks have more advanced melanoma in association with worse survival rates; however, melanoma disparity among Hispanics is less recognized. The dearth of studies on melanoma among Hispanics partly reflects the small number of cases in many areas of the United States, as well as limitations of ethnicity information in cancer registries. In fact, the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program and most other cancer registries did not begin classifying data for "Hispanic" until the late 1990s. As a result, few studies included data regarding Hispanics.

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.

1. Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly* 2005;83(3):457-502.

2. Hu A, Parmet Y, Allen G, Parker DF, et al. Disparity in Melanoma. A Trend Analysis of Melanoma Incidence and Stage at Diagnosis Among Whites, Hispanics, and Blacks in Florida. *Arch Dermatol*. 2009;145(12):1369-1374.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, Patient/societal consequences of poor quality

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.

In the year 2010, an estimated 68,130 new cases of melanoma were diagnosed and about 8,700 patients died of the disease in the

United States. However, these figures for new cases may represent a substantial underestimation, because many superficial and in situ melanomas treated in the outpatient setting are not reported. The incidence of melanoma continues to increase dramatically. Melanoma is increasing in men more rapidly than any other malignancy and, in women more rapidly than any other malignancy except lung cancer. The lifetime risk of developing melanoma in the year 2005 for someone born in the United States may be as high as one in 55. The median age at diagnosis is 59 years. As such, melanoma ranks second to adult leukemia in terms of loss of years of potential life, per death.(1)

Melanoma is among the top 10 new cancer diagnoses for both American men and women. Nationally, melanoma incidence has increased 2.4% annually in the last decade.(2)

Estimates of the overall risk of recurrence in local, cutaneous melanoma vary between 15–35%.(3)

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

1. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology: Melanoma. 3.2012. Available at: www.nccn.org

2. Hu A, Parmet Y, Allen G, Parker DF, et al. Disparity in Melanoma. A Trend Analysis of Melanoma Incidence and Stage at Diagnosis Among Whites, Hispanics, and Blacks in Florida. Arch Dermatol. 2009;145(12):1369-1374.

3. Mooney MM, Mettlin C, Michalek AM, Petrelli NJ, Kraybill WG. Lifelong Screening of Patients with Intermediate-Thickness Cutaneous Melanoma for Asymptomatic Pulmonary Recurrences. A Cost Effective Analysis. Cancer 1997;80:1052-64.

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):
[Cancer](#), [Cancer : Skin](#)

De.6. Non-Condition Specific (check all the areas that apply):
[Care Coordination](#)

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.)

The updated specifications for this measure are included within this form. Additional measure information can be found at www.physicianconsortium.org.

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

[This is not an eMeasure](#) **Attachment:**

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

No data dictionary Attachment:

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Patients whose information is entered, at least once within a 12 month period, into a recall system that includes:

- A target date for the next complete physical skin exam , AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

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.)

Once during the measurement period

S.6. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Numerator Instructions:

To satisfy this measure, the recall system must be linked to a process to notify patients when their next physical exam is due, and to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment and must include the following elements at a minimum: patient identifier, patient contact information, cancer diagnosis(es), date(s) of initial cancer diagnosis (if known), and the target date for the next complete physical exam.

For Claims:

Report CPT Category II code: 7010F – Patient information entered into a recall system that includes: target date for the next exam specified AND a process to follow up with patients regarding missed or unscheduled appointments

For EHR:

This measure does not lend itself to a “traditional specification” for EHR reporting. This is a structural measure; each facility may have a different process or software system for tracking and transmitting recalls as well as different appointment tracking systems.

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

All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma

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

Elderly

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)

For Claims:

Melanoma or history of melanoma ICD-9-CM diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82

Melanoma or history of melanoma ICD-10-CM diagnosis codes: C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9, Z85.820

AND

CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

For EHR:

This measure does not lend itself to a “traditional specification” for EHR reporting. This is a structural measure; each facility may have a different process or software system for tracking and transmitting recalls as well as different appointment tracking systems.

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

The PCPI exception methodology uses three categories of exception reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include system reason(s) for not entering patients into a recall system (eg, melanoma being monitored by another physician provider). Where examples of exceptions are included in the measure language, value sets for these examples are developed and are included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients’ medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician’s exceptions data to identify practice patterns and opportunities for quality improvement.

Documentation of system reason(s) for not entering patients into a recall system (eg, melanoma being monitored by another physician provider)

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)*

For Claims:

Report CPT Category II code with a modifier:

7010F-3P – Documentation of system reason(s) for not entering patients into a recall system (eg, melanoma being monitored by another physician provider)

For EHR:

This measure does not lend itself to a “traditional specification” for EHR reporting. This is a structural measure; each facility may have a different process or software system for tracking and transmitting recalls as well as different appointment tracking systems.

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)*

We encourage the results of this measure to be stratified by race, ethnicity, primary language, and administrative sex.

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)*

Not applicable

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.)

To calculate performance rates:

- 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).
- 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.
- 3) From the patients within the denominator, find the patients who qualify for the numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.
- 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: system reason(s) (eg, melanoma being monitored by another physician provider)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. –Although exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

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.

Not applicable. The measure does not require sampling or a survey.

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.

Claims, Electronic Health Records, Other, Paper Medical Records, Registry Data

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

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

Not Applicable

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)
[Clinician : Group/Practice](#), [Clinician : Individual](#)

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)
[Outpatient Services](#)
 If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

[0650_MeasureTesting_MSF5.0_Data.doc](#)

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

[generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition](#)
 If other:

3b. Electronic Sources

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

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

[ALL data elements are in defined fields in electronic health records \(EHRs\)](#)

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

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

Attachment:

3c. Data Collection Strategy

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

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and

cost of data collection, other feasibility/implementation issues.

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

This measure was found to be reliable and feasible for implementation.

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	
Professional Certification or Recognition Program	
Quality Improvement (Internal to the specific organization)	

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

We are not aware of any unintended consequences related to this measurement.

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.)

[No competing measures have been identified.](#)

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): [American Academy of Dermatology](#)

Co.2 Point of Contact: [Joshua, Nyirenda, JNyirenda@aad.org, 202-609-6329-](#)

Co.3 Measure Developer if different from Measure Steward: [American Academy of Dermatology](#)

Co.4 Point of Contact: [Joshua, Nyirenda, JNyirenda@aad.org, 202-609-6329-](#)

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.

[Steven D. Bines, MD \(general surgery\)](#)

[Peter Dandalides, MD \(health plan\)](#)

[Evan R. Farmer, MD \(dermatology\)](#)

[Rutledge Fourney, MD \(dermatology\)](#)

[Andrea Gelzer, MD MS FACP \(health plan\)](#)

[Robert T. Gilson, MD \(dermatology\)](#)

[Stephen E. Helms, MD \(dermatology\)](#)

[Abrar Qureshi, MD \(dermatology\)](#)

[Todd Schlessinger, MD \(dermatology\)](#)

[John Schneider, MD, PhD \(family medicine\)](#)

[Arthur Joel Sober, MD \(dermatology\)](#)

[Steven W. Strobe, MD, MEd, MPH \(family medicine\)](#)

[Janet \(Jessie\) Sullivan, MD \(dermatology\)](#)

[William Wooden, MD \(plastic surgery\)](#)

[PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study must be equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.](#)

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: [2007](#)

Ad.3 Month and Year of most recent revision: [09, 2010](#)

Ad.4 What is your frequency for review/update of this measure? [Please see Additional Information/Comments](#)

Ad.5 When is the next scheduled review/update for this measure? [09, 2012](#)

Ad.6 Copyright statement: Physician Performance Measures (Measures) and related data specifications, developed by the American Medical Association

(AMA) in collaboration with the Physician Consortium for Performance Improvement (the Consortium) and the National Committee for Quality Assurance (NCQA) pursuant to government sponsorship under subcontract 6205-05-054 with Mathematica Policy Research, Inc. under contract 500-00-0033 with Centers for Medicare & Medicaid Services.

These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA, (on behalf of the Consortium) or NCQA. Neither the AMA, NCQA, Consortium nor its members shall be responsible for any use of the Measures.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.

© 2004-6 American Medical Association and National Committee for Quality Assurance. All Rights Reserved.

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, NCQA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

CPT® contained in the Measures specifications is copyright 2005 American Medical Association.

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: Coding/Specifications updates occur annually. The PCPI has a formal measurement review process that stipulates regular (usually on a three-year cycle, when feasible) review of the measures. The process can also be activated if there is a major change in scientific evidence, results from testing or other issues are noted that materially affect the integrity of the measure.