



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 #: 1825

Corresponding Measures:

De.2. Measure Title: COPD - Management of Poorly Controlled COPD

Co.1.1. Measure Steward: ActiveHealth Management

De.3. Brief Description of Measure: The percentage of patients age 18 years or older with poorly controlled COPD, who are taking a long acting bronchodilator.

1b.1. Developer Rationale: The use of long acting bronchodilators in patients with evidence of poorly controlled COPD (as evidenced by the recent exacerbations), is expected to reduce exacerbations and improve symptom control to a greater degree compared with short-acting bronchodilator agents alone.

S.4. Numerator Statement: Patients age 18 years or older with poorly controlled COPD, who are taking a long acting bronchodilator

S.7. Denominator Statement: Patients age 18 years and older with poorly controlled COPD who are taking a short acting bronchodilator

S.10. Denominator Exclusions: Patients who had a lung transplant or at least 2 diagnosis for conditions, other than COPD requiring steroids (e.g. Cerebral arteritis, other organ transplant, glomerulonephritis, etc.).

De.1. Measure Type: Process

S.23. Data Source: Claims, Electronic Health Data, Electronic Health Records, Instrument-Based Data

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

IF Endorsement Maintenance – Original Endorsement Date: Jul 31, 2012 **Most Recent Endorsement Date:** Jul 31, 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
[1825_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)

The use of long acting bronchodilators in patients with evidence of poorly controlled COPD (as evidenced by the recent exacerbations), is expected to reduce exacerbations and improve symptom control to a greater degree compared with short-acting bronchodilator agents alone.

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.

There is limited published data on performance gaps regarding the use of long acting bronchodilators in poorly controlled COPD. ActiveHealth benchmark data has demonstrated that gaps can be detected. Our 2011 data identified that 24 percent of patients with poorly controlled COPD and experiencing exacerbations, were not being prescribed long-acting bronchodilators in the past 1 year.

A cross-sectional study designed to assess attitudes and barriers to COPD guideline usage by surveying 500 primary care physicians found that only 25.8% reported adherence to guidelines related to long-acting bronchodilator (LABD) use in COPD patients. This demonstrates a significant opportunity for performance improvement in the use of LABDs in COPD.

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.

Barriers to adherence to chronic obstructive pulmonary disease guidelines by primary care physicians

Gregory D Salinas, James C Williamson, Ravi Kalhan, Byron Thomashow, Jodi L Scheckermann, John Walsh, Maziar Abdolrasulnia, and Jill A Foster

Int J Chron Obstruct Pulmon Dis. 2011; 6: 171–179.

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.

There is no available data on disparities by population groups on the use of bronchodilators in COPD.

There is evidence on racial disparities in prevalence of COPD. Because the popularity of cigarette smoking increased later among women and African Americans than in white men, rates of COPD among these groups have risen more recently. Although in several years before 1995 the rate of COPD among whites was higher than among African Americans, more recently there has been no difference between the two groups. In the early 1980s hospitalization rates for COPD were higher among whites than African Americans; however, since 1987 rates have been similar reflecting a decline among whites and an increase among blacks. Throughout the period, rates of emergency room care for COPD were higher among African Americans than whites, whereas the reverse was true for rates of physician office visits. It is not clear whether this disparity results from self-selection or socioeconomic barriers to access to care among blacks.

Similarly, there is evidence on racial disparities in treatment of COPD, in the application of smoking cessation programs, home oxygen use, and influenza vaccination. African Americans are less likely than Caucasians to receive smoking cessation advice from their physicians. Amongst patients with COPD, there is evidence to indicate that African Americans get influenza vaccination less frequently than Caucasians. Similarly, African Americans are less likely to receive ambulatory oxygen therapy than their white counterparts.

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.

COPD: Racial Disparities in Susceptibility, Treatment, and Outcomes. Mark T. Dransfield, MD, William C. Bailey, MD. Clin Chest Med 27 (2006) 463–471.

Racial and sex differences in chronic obstructive pulmonary disease susceptibility, diagnosis, and treatment. deNay P. Kirkpatrick and Mark T. Dransfield. Curr Opin Pulm Med 15:100–104.

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, A leading cause of morbidity/mortality, High resource use

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.

COPD is the third leading cause of death in America, claiming the lives of 124,477 Americans in 2007.¹ In 2008, 13.1 million U.S. adults (aged 18 and over) were estimated to have COPD.² However, close to 24 million U.S. adults have evidence of impaired lung function, indicating an under diagnosis of COPD.³ An estimated 672,000 hospital discharges were reported in 2006; a discharge rate of 22.5 per 100,000 population. COPD is an important cause of hospitalization in our aged population. Approximately 64% of discharges were in the 65 years and older population in 2006.⁴ A Lung Association survey revealed that half of all COPD patients (51%) say their condition limits their ability to work. It also limits them in normal physical exertion (70%), household chores (56%), social activities (53%), sleeping (50%) and family activities (46%).⁵ In 2010, the cost to the nation for COPD was projected to be approximately \$49.9 billion, including \$29.5 billion in direct health care expenditures, \$8.0 billion in indirect morbidity costs and \$12.4 billion in indirect mortality costs.^{6,7}

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

1. Centers for Disease Control and Prevention. National Center for Health Statistics. Final Vital Statistics Report. Deaths: Final Data for 2007. Vol. 58, No. 19, May 2010.

2. Centers for Disease Control and Prevention. National Center for Health Statistics: National Health Interview Survey Raw Data, 2008. Analysis performed by American Lung Association Research and Program Services using SPSS and SUDAAN software.

3. Centers for Disease Control and Prevention. Chronic Obstructive Pulmonary Disease Surveillance – United States, 1971-2000. Morbidity and Mortality Weekly Report. August 2, 2002; 51(SS06):1-16.

4. Centers for Disease Control and Prevention. National Center for Health Statistics. National Hospital Discharge Survey, 1979-2006. 2006 Unpublished Data.

5. Confronting COPD in America, 2000. Schulman, Ronca and Bucuvalas, Inc. (SRBI) Funded by Glaxo Smith Kline.

6. U.S. Department of Health and Human Services. National Institutes of Health. National Heart Lung and Blood Institute. Morbidity and Mortality: 2009 Chartbook on Cardiovascular, Lung and Blood Diseases.

7. American Lung Association. Chronic Obstructive Pulmonary Disease (COPD) Fact Sheet. http://www.lungusa.org/lung-disease/copd/resources/facts-figures/COPD-Fact-Sheet.html#note_01

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):

Respiratory, Respiratory : Chronic Obstructive Pulmonary Disease (COPD)

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

Population Health

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.)

www.activehealth.com/nqf-measures-with-articles

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

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

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

Attachment Attachment: [NQF_1825_CODE_SET_2013.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.

[Patients age 18 years or older with poorly controlled COPD, who are taking a long acting bronchodilator](#)

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.)

[12 months](#)

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.

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

Numerator Rule:

One of the following:

1. Presence of at least 1 refill of BRONCHODILATOR (LONG ACTING) medication from claims or HIE in the past 12 months
2. Presence of patient data via online PHR or telephonic nurse assessment confirming 1 refill of BRONCHODILATOR (LONG ACTING) in the past 12 months
3. Presence of feedback from provider or patients indicating BRONCHODILATOR (LONG ACTING) already implemented

[See attachment for code set](#)

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

[Patients age 18 years and older with poorly controlled COPD who are taking a short acting bronchodilator](#)

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 rule:

All of the following expressions:

1. If patient age is greater than or equal to 18 years
2. One of the following:
 - a. Presence of at least 1 PM COPD diagnosis from HIE in the past 12 months
 - b. Presence of at least 2 PM COPD diagnosis from claims in the past 12 months
 - c. Presence of patient data via online PHR or telephonic nurse assessment confirming at least 1 PDD- COPD Result anytime in the past
3. One of the following:
 - a. Presence of at least 2 refills of B-AGONIST (SHORT ACTING-INHALED) from claims in the past 12 months
 - b. Presence of at least 2 refills of INHALED ANTICHOLINERGIC DRUGS (SHORT-ACTING) from claims in the past 12 months
 - c. Presence of at least 2 refills of INHALED ANTICHOLINERGIC AND BETA-AGONIST COMBO from claims in the past 12 months
4. One of the following:
 - a. Presence of at least 1 PM COPD diagnosis overlaps within 3 days of 1 COPD ACUTE TREATMENT procedure from claims in the past 12 months
 - b. All of the following:
 - i. Presence of 1 refill of STEROIDS >/ 5MG PREDNISONE from claims in the past 12 months
 - ii. Presence of at least 1 PM COPD diagnosis overlaps within 3 days of 1 Refill of STEROIDS >/ 5MG PREDNISONE from claims in the past 12 months

See attachment for code set

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

Patients who had a lung transplant or at least 2 diagnosis for conditions, other than COPD requiring steroids (e.g. Cerebral arteritis, other organ transplant, glomerulonephritis, etc.).

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)

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

One of the following:

1. Presence of at least 1 TRANSPLANT LUNG (CPT) Procedure from claims in the past 3 years
2. Presence of At Least 1 TRANSPLANT LUNG (ICD9) Diagnosis from claims in the past 3 Years
3. Presence of at least 2 STEROIDS-INDICATIONS diagnosis from claims in the past 24 months excluded from only line 4 above in S.9. Denominator Details

See attachment for code set

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)

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

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)

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

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.)

Calculation algorithm (see measure logic above)

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.

This measure does not require a 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 Data, Electronic Health Records, Instrument-Based Data

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

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

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 Disease Management), lifestyle coaching program (Active Lifestyle Coaching), and maternity program (Active Maternity Management), as well as through our electronic patient health record (myActiveHealth). Data may also be entered by clinicians and their extenders through our online physician portal (Active Care Team Suite).

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

URL

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

Health Plan, 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 care settings when testing as we accept data from all care settings

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

1825_MeasureTesting_MSFS.0_Data.doc

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

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: We are able to ingest and process self-reported patient data, data from disease management programs, and data from providers.

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 a combination of electronic sources

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

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.

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.

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, 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.

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

0102 : COPD: inhaled bronchodilator therapy
0549 : Pharmacotherapy Management of COPD Exacerbation (PCE)

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?

No

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

While NQF Measure 0102 addresses the same condition (COPD), it addresses the basic need for COPD patients to have at least an inhaled bronchodilator. Our measure specifically concentrates on the further management of those COPD patients who are poorly controlled and are already taking an inhaled bronchodilator, thereby on the next level of treatment of symptoms. NQF Measure 0549 addresses those COPD patients in the hospital or who have been seen in the ED and are 40 years of age and older, and who have been dispensed a systemic corticosteroid within 14 days of the event and dispensed a bronchodilator within 30 days of the event. Our measure, on the other hand, addresses the need for further treatment in all adults with a diagnosis of COPD, regardless of care setting, who are already on therapy and continue to experience COPD exacerbations.

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 does not have both the same target population and the same measure focus as any other NQF-endorsed measure.

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, 212-652-8200-

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

Co.4 Point of Contact: Lindee, Chin, lchin@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.

Bani Vir, MD: Medical Director, Clinical Research & Development, ActiveHealth Management, Inc.
Lindee Chin, MD: Medical Director, Clinical Research & Development, ActiveHealth Management, Inc.
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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.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2011

Ad.3 Month and Year of most recent revision:

Ad.4 What is your frequency for review/update of this measure? Annually

Ad.5 When is the next scheduled review/update for this measure? 01, 2013

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Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: The username and password for URL listed in Section S1 are:

Username: activehealth

Password: AH\$1@2