



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 #: 1959

Corresponding Measures:

De.2. Measure Title: Human Papillomavirus Vaccine for Female Adolescents (HPV)

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

De.3. Brief Description of Measure: Percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

1b.1. Developer Rationale: This measure requires that females receive all three recommended doses of the HPV vaccines by age 13. Administering widespread vaccination for HPV has the potential to reduce cervical cancer deaths around the world by as much as two-thirds of all young, sexually active women received the vaccine and if protection turns out to be long-term. The HPV vaccine could reduce the need for medical care, biopsies and invasive procedures associated with follow-up from abnormal Pap tests, therefore reducing health care costs from abnormal Pap tests and follow-up procedures (National Cancer Institute, 2009). It is important to administer the HPV vaccine to girls before their first sexual contact or experience. Once an adolescent girl or woman has been infected with the virus—possibly during her first sexual encounter—the vaccine might not work as well, or at all (CDC, 2010).

S.4. Numerator Statement: Female adolescents who had at least three doses of the human papillomavirus (HPV) vaccine with different dates of service between their 9th and 13th birthdays.

S.7. Denominator Statement: Female adolescents who turned 13 years of age during the measurement year.

S.10. Denominator Exclusions: Adolescents who had a contraindication for the HPV vaccine.

De.1. Measure Type: Process

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

S.26. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System

IF Endorsement Maintenance – Original Endorsement Date: Jun 06, 2012 **Most Recent Endorsement Date:** Jun 04, 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? NA

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
1959_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)

This measure requires that females receive all three recommended doses of the HPV vaccines by age 13. Administering widespread vaccination for HPV has the potential to reduce cervical cancer deaths around the world by as much as two-thirds of all young, sexually active women received the vaccine and if protection turns out to be long-term. The HPV vaccine could reduce the need for medical care, biopsies and invasive procedures associated with follow-up from abnormal Pap tests, therefore reducing health care costs from abnormal Pap tests and follow-up procedures (National Cancer Institute, 2009). It is important to administer the HPV vaccine to girls before their first sexual contact or experience. Once an adolescent girl or woman has been infected with the virus—possibly during her first sexual encounter—the vaccine might not work as well, or at all (CDC, 2010).

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.

In the U.S., adolescent immunization rates have historically lagged behind early childhood immunization rates. In 2000, the American Academy of Pediatrics reported that 35 million adolescents failed to receive at least one recommended vaccination (Little, 2000). Low immunization rates among adolescents have the potential to cause outbreaks of preventable diseases and to establish reservoirs of disease in adolescents that can affect other populations, including infants, the elderly and individuals with chronic conditions. Immunization recommendations for adolescents have changed in recent years. In addition to catch-up immunizations that may have been missed during childhood and infancy, there are new vaccines targeted specifically to adolescents. The ACIP recommended the following immunizations for adolescents age 11–12 years:

- One dose Tdap (or Td)
- Three doses of HPV4 or HPV2
- One dose MCV4 (or MPSV4)

The HPV vaccine was approved by the Food and Drug Administration in 2006 and incorporated into ACIP recommendations published in March 2007. Since then, early reports indicated that about one quarter (25.1 percent) of adolescent females age 13–17 had initiated the vaccine series (>one dose) (MMWR, 2008). An estimated 32.3 percent had received one dose, 44.2 percent had received two doses and 23.5 percent had received three doses (MMWR, 2008). 2008 was the first year HPV coverage was reported.

During a study in a nationally representative network of pediatricians and family physicians, few felt strongly about recommending the vaccination to 11- and 12-year-olds than to adolescents older than 13. The most frequently reported barriers to HPV vaccination among female patients at the younger ages included: financial burden (e.g., vaccine cost, lack of insurance coverage); considering it necessary to discuss sexuality prior to recommending vaccination; and parent refusal (Daley et al., 2010).

Parental acceptance of the HPV vaccine affects vaccine usage. One study found that 25 percent of parents have reservations about having their daughters immunized because of the concern that vaccination might influence their daughters' sexual behaviors; their uneasiness about the morality of immunizing to prevent sexually transmitted infections; and worries about the safety of the vaccine (Constantine, 2006).

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.

Daley, M., L. Crane, L. Markowitz, S. Black, B. Beaty, J. Barrow, C. Babbel, S. Gottlieb, N. Liddon, S. Stokley, L. Dickinson, A. Kempe. 2010. Human Papillomavirus Vaccination Practices: A Survey of US Physicians 18 Months After Licensure Pediatrics 126:425–33.

Constantine, N.A., P. Jerman. 2007. Acceptance of human Papillomavirus vaccination among Californian parents of daughters: a representative statewide analysis. J Adol Health 40; 108–15.

Little, J. 2000. 35 million teens missing recommended vaccines. AAP News. 17(3):81.

Centers for Disease Control and Prevention. October 10, 2008. Vaccination Coverage Among Adolescents Aged 13–17 Years—United States, 2007. MMWR. 57(40);1100–3.

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.*

Variations in immunization coverage exist among some populations. Children of lower socioeconomic status are less likely to be fully immunized because the vaccine is expensive (\$120–\$125 per dose, on average, for the three-shot series). While some health insurance plans cover the costs of the HPV vaccine doses and clinic visits, not all do. Those without coverage are unlikely to be able to afford the vaccine. Children age 18 and younger who are eligible for the Vaccines for Children (VFC) program, including those who are Medicaid eligible, uninsured or American Indian or Alaska Native, may be able to receive the HPV vaccine for a nominal cost.

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.

NCHS. Health, United States, 2009. <http://www.cdc.gov/nchs/hus.htm>

CDC. Eliminate Disparities in Adult & Child Immunization Rates. <http://www.cdc.gov/omhd/amh/factsheets/immunization.htm> Updated June 5, 2007.

Kane, Mark & Lasher, Heidi. The Case for Childhood Immunization.

<http://www.savic.ac.za/backend/docs/A%20case%20for%20childhood%20immunisation.pdf> Updated March 2002.

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, Severity of illness, 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.

Sexually transmitted diseases (STD) are among the most common infections in American youths (Daley et al., 2010). The most common sexually transmitted virus in the U.S. is genital human papillomavirus (HPV). It is contracted through genital contact, such as vaginal and anal sex. According to the CDC, at least 50 percent of all sexually active people will have genital HPV at some point during their lifetime (CDC, 2010). Approximately 20 million Americans are infected with genital HPV, which is responsible for nearly 70 percent of cases of cervical cancer and 90 percent of cases of anogenital warts. This is a growing global concern, especially considering that the number of morbidities and deaths associated with HPV infections could be prevented through vaccination (Daley et al., 2010).

Preventing disease through vaccination eliminates direct costs associated with treating the disease, including doctor visits and hospital stays, as well as indirect costs, including time lost from work. A quadrivalent HPV vaccine was first licensed in the U.S. in June 2006. The vaccine was initially approved for female patients 9–26 years of age. Currently, HPV vaccination is recommended for female patients at 11 and 12 years of age. The median age of the first sexual experience for Americans is 17 years. Thirteen percent of girls initiate sexual activity before the age of 15, and 4 percent before the age of 13. A “catch-up” vaccination is recommended for unimmunized female patients between 13 and 26 years of age (CDC, 2010).

HPV is extremely common and easily transmitted. Any form of genital contact is sufficient for HPV transmission, meaning having only one sexual partner can result in infection. Nearly all sexually active adolescents are at high risk of acquiring the virus (Moscicki, 2005). In a study synthesizing existing literature on the economic and financial burden of STDs in the U.S., researchers ranked HPV and HIV as being the most costly in terms of total estimated direct medical costs, together accumulating 90 percent of the total \$6.5 billion estimated burden for STDs (Chesson et al., 2004).

In a study of STDs among youths in America, researchers estimated that costs attributable to the HPV infections, for those infected between 15 and 24, include \$2.7 billion for follow-up of abnormal Pap smear results and treatment of cervical neoplasia, \$108.3

million for direct medical costs associated with invasive cervical cancer and \$123.9 million for the treatment of external anogenital warts. The total annual cost of HPV infection attributable to infections acquired during this age range is \$2.8 billion for women and \$62 million for men (Chesson et al., 2004).

Currently, there are two HPV vaccines licensed by the FDA and recommended by CDC. Both vaccines are considered extremely effective against HPV types 16 and 18, responsible for most cervical cancers. Each requires three doses given as shots. The CDC recommends that all girls between 11 and 12 years of age get the three doses of either vaccine, although the three doses should be a consistent brand of the vaccine. For the vaccine to work best, all three doses should be given to girls before exposure to HPV (i.e., before they become sexually active). The first dose of the HPV vaccine should be given to girls during a pre-teen health check-up. Both HPV vaccine brands are safe to administer with other pre-teen vaccines. The CDC recommends that the second dose be given one to two months after the first dose, and that the third be given six months after the first. There are no studies showing whether one or two doses of the vaccine protect as well as all three doses; therefore, girls are encouraged to get all three (CDC, 2010).

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

Centers for Disease Control and Prevention. Sexually Transmitted Diseases. HPV: Common Infection, Common Reality. Last Updated: June 3, 2010. <http://www.cdc.gov/std/hpv/common-downloads.htm>

Centers for Disease Control and Prevention. Vaccines and Preventable Diseases: HPV Vaccine—Questions & Answers. <http://www.cdc.gov/vaccines/vpd-vac/hpv/vac-faqs.htm>

Cates, W. Jr. 1999. Estimates of the Incidence and Prevalence of Sexually Transmitted Diseases in the United States. Sexually Transmitted Diseases: 26(4):S2-S7.

Chesson, H., J. Blandford, T. Gift, G. Tao, K. Irwin. 2004. The Estimated Direct Medical Cost of Sexually Transmitted Diseases Among American Youth, 2000. Perspect Sex Reprod Health. 36(1):11-9.

Daley, M., L. Crane, L. Markowitz, S. Black, B. Beaty, J. Barrow, C. Babbel, S. Gottlieb, N. Liddon, S. Stokley, L. Dickinson, A. Kempe. 2010. Human Papillomavirus Vaccination Practices: A Survey of US Physicians 18 Months After Licensure Pediatrics 126:425-33.

Moscicki, A. 2005. Impact of HPV Infection in Adolescent Populations. Journal of Adolescent Health. 37:S3-S9.

Weinstock, H., S. Berman, W. Cates, Jr. 2004. Sexually transmitted diseases among American youth: incidence and prevalence estimates, 2000. Perspect Sex Reprod Health. 36(1):6-10.

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

2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

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

Primary Prevention

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

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

the specifications)

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

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

[Attachment 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.

[Female adolescents who had at least three doses of the human papillomavirus \(HPV\) vaccine with different dates of service between their 9th and 13th birthdays.](#)

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.)

[2 years](#)

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.

[ADMINISTRATIVE](#)

[At least three HPV vaccinations \(HPV Vaccine Administered Value Set\), with different dates of service, on or between the patient's 9th and 13th birthdays. HPV vaccines administered prior to a member's 9th birthday cannot be counted.](#)

[- See corresponding Excel document for the HPV Vaccine Administered Value Set](#)

[---](#)

[MEDICAL RECORD](#)

[At least three HPV vaccinations, with different dates of service, on or between the patient's 9th and 13th birthdays.](#)

[For immunization evidence obtained from the medical record, the organization may count patients where there is evidence that the antigen was rendered from either of the following:](#)

- [• A note indicating the name of the specific antigen and the date of service, OR](#)
- [• A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered](#)

[HPV vaccines administered prior to a member's 9th birthday cannot be counted.](#)

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

[Female adolescents who turned 13 years of age during the measurement year.](#)

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

[Children](#)

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)

[Female adolescents who turned 13 years of age during the measurement year.](#)

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

Adolescents who had a contraindication for the HPV vaccine.

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)*

Either of the following meet optional exclusion criteria:

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the patient's 13th birthday.

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011.

See corresponding Excel document for the above value sets

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)*

NA

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)*

NA

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.)*

Step 1: Determine the denominator. Identify female adolescents who turned 13 years of age during the measurement year.

Step 2: Apply any denominator exclusions. Identify patients with anaphylactic reaction to the vaccine or its components any time on or before the patient's 13th birthday or patients with anaphylactic reaction to the vaccine or its components with a date of service prior to October 1, 2011.

Step 3: Determine the numerator. Identify patients with at least three HPV vaccinations, with different dates of service, on or

between the patient's 9th and 13th birthdays. HPV vaccines administered prior to a member's 9th birthday cannot be counted.

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.

A systematic sample drawn from the eligible population. Organizations that use the Hybrid Method to report the Immunizations for Adolescents measure may use the female members from the IMA sample as a start for this measure and, using the sampling methodology in the Guidelines for Calculations and Sampling, may draw enough additional female members from the remaining eligible population of this measure until the full sample size and appropriate oversample is reached. Organizations may reduce the sample size using the current year's HPV administrative rate. For information on reducing the sample size, refer to the Guidelines for Calculations and Sampling.

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, 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.

HEDIS Technical Specifications for Health Plans

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, Health Plan, Integrated Delivery System

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

1959_MeasureTesting_MS5.0_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), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

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.

Based on field test results, we have specified the measure to assess whether female adolescents are receiving all three HPV vaccination doses between the ages of 9 and 13 years. Our field test results show that these data elements are available and feasible to collect. In addition, our field test participants noted that many were able to program these requirements into their electronic health record systems, and several implemented point-of-service physician reminders for this measure.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (*e.g., value/code set, risk model, programming code, algorithm*).

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

| Planned | Current Use (for current use provide URL) |
|---|---|
| Public Reporting | |
| Regulatory and Accreditation Programs | |
| 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.

During the measure development process, the measure development team worked with our advisory panels as well as NCQA's certified auditors and audit department to ensure that the measure specifications were clear and auditable. The denominator, numerator and optional exclusions are concisely specified and align with our audit standards.

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.)

NA

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 |
| <p>Co.1 Measure Steward (Intellectual Property Owner): National Committee for Quality Assurance</p> <p>Co.2 Point of Contact: Bob, Rehm, nqf@ncqa.org, 202-955-1728-</p> <p>Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance</p> <p>Co.4 Point of Contact: Kristen, Swift, Swift@ncqa.org, 202-955-5174-</p> |
| Additional Information |
| <p>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. The Child Health Measurement Advisory Panel is a multi-stakeholder panel that guided the development of the measures, including reviewing evidence, specifications, field test results, and public comment results. Members: Jeanne Alicandro, Barbara Dailey, Denise Dougherty, Ted Ganiats, Foster Gesten, Nikki Highsmith, Charles Homer, Jeff Kamil, Elizabeth Siteman, Mary McIntyre, Virginia Moyer, Lee Partridge, Xavier Sevilla, Michael Siegal, Janet Sullivan</p> |
| <p>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: 03, 2012 Ad.4 What is your frequency for review/update of this measure? Approximately 3 yrs depending on external factors e.g. release of new evidence or updated guidelines Ad.5 When is the next scheduled review/update for this measure? 07, 2013</p> |
| <p>Ad.6 Copyright statement: © 2009 by the National Committee for Quality Assurance 1100 13th Street, NW, Suite 1000 Washington, DC 20005 Ad.7 Disclaimers:</p> |
| Ad.8 Additional Information/Comments: |