



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 sub criterion 1b).

Brief Measure Information

NQF #: 2993

Corresponding Measures:

De.2. Measure Title: Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)

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

De.3. Brief Description of Measure: The percentage of patients 65 years of age and older who have evidence of an underlying disease, condition or health concern and who are dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis. Three rates are reported for this measure:

-Rate 1: The percentage of those with a history of falls that received a potentially harmful medication

-Rate 2: The percentage of those with dementia that received a potentially harmful medication

-Rate 3: The percentage of those with chronic kidney disease that received a potentially harmful medication

A lower rate represents better performance for all rates.

1b.1. Developer Rationale: Lowering the rate of potentially harmful drug-disease interactions in the older adult population should decrease morbidity and mortality associated with adverse drug reactions.

S.4. Numerator Statement: Numerator 1: Patients with a history of falls who received at least one potentially harmful medication from Table DDE-A or Table DDE-B

Numerator 2: Patients with a diagnosis of dementia who received at least one potentially harmful medication from Table DDE-D

Numerator 3: Patients with chronic kidney disease who received at least one potentially harmful medication from Table DDE-E

S.6. Denominator Statement: All patients 65 years of age and older with a history of falls, dementia or chronic kidney disease in the measurement year or the year prior to the measurement year.

S.8. Denominator Exclusions: For those who meet denominator criteria for the history of falls rate (Rate 1): exclude those with a diagnosis of psychosis, schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder or seizure disorder.

For those who meet denominator criteria for the dementia rate (Rate 2): exclude those with a diagnosis of psychosis, schizophrenia, schizoaffective disorder or bipolar disorder.

De.1. Measure Type: Process

S.17. Data Source: Claims

S.20. Level of Analysis: Health Plan

IF Endorsement Maintenance – Original Endorsement Date: Jan 26, 2017 **Most Recent Endorsement Date:** Jan 26, 2017

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? N/A

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 sub criteria to pass this criterion and be evaluated against the remaining criteria.***

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[Final_DDE_evidence_attachment_7.1.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

Yes

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., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Lowering the rate of potentially harmful drug-disease interactions in the older adult population should decrease morbidity and mortality associated with adverse drug reactions.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. 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 include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

The following data are extracted from HEDIS data collection for Medicare Advantage Health Plans (including both HMO and PPO plans). Performance data is summarized at the health plan level and summarized by mean, standard deviation, and performance at the 10th, 25th, 50th, 75th and 90th percentile. Data is stratified by year.

Rate 1 (History of Falls)^

YEAR | N | MEAN | ST DEV | MIN | 10TH (Better) | 25TH | 50TH | 75TH | 90TH (Worse) | MAX

2016 | 390 | 47.1% | 8.3 | 0.0% | 38.2% | 43.0% | 46.8% | 51.9% | 57.4% | 74.1%

2017 | 411 | 48.2% | 8.3 | 0.0% | 39.1% | 43.3% | 47.6% | 52.6% | 58.7% | 75.7%

2018* | 402 | 48.7% | 7.5 | 25.8% | 39.6% | 43.8% | 48.3% | 53.6% | 58.7% | 76.6%

*For 2018 the average eligible population was 2,481, with a standard deviation of 5,368

^Note: These results are based on a previous specification of the HEDIS measure that does not include SNRI medications and the associated exclusion for major depressive disorder.

Rate 2 (Dementia)

YEAR | N | MEAN | ST DEV | MIN | 10TH (Better) | 25TH | 50TH | 75TH | 90TH (Worse) | MAX

2016 | 385 | 45.5% | 8.3 | 9.8% | 36.2% | 40.5% | 44.6% | 50.0% | 55.7% | 77.7%

2017 | 408 | 46.5% | 8.5 | 19.5% | 37.3% | 40.7% | 45.2% | 51.7% | 57.2% | 75.3%

2018* | 407 | 45.5% | 8.3 | 23.6% | 36.1% | 40.0% | 44.3% | 50.5% | 56.7% | 75.0%

*For 2018 the average eligible population was 1,974, with a standard deviation of 4,073

Rate 3 (Chronic Kidney Disease)

YEAR | N | MEAN | ST DEV | MIN | 10TH (Better) | 25TH | 50TH | 75TH | 90TH (Worse) | MAX

2016 | 344 | 10.0% | 6.4 | 0.8% | 3.8% | 5.8% | 8.3% | 12.6% | 18.4% | 43.5%

2017 | 369 | 10.2% | 6.5 | 0.0% | 3.5% | 5.9% | 8.6% | 12.9% | 18.8% | 42.6%

2018* | 377 | 10.2% | 6.6 | 0.0% | 3.8% | 5.9% | 8.4% | 12.7% | 18.8% | 39.4%

*For 2018 the average eligible population was 998, with a standard deviation of 2,035

The data referenced are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. In 2018, HEDIS measures covered more than 21 million Medicare enrollees. Below is a description of the denominator for this measure. It includes the number of health plans reporting the measure and the mean denominator for the measure across health

plans.

Rate 1 (History of Falls)

YEAR | N Plans | Median Denominator Size per plan | Mean Denominator Size per plan

2016 | 390 | 616 | 1,919

2017 | 411 | 632 | 2,142

2018 | 402 | 719 | 2,481

Rate 2 (Dementia)

YEAR | N Plans | Median Denominator Size per plan | Mean Denominator Size per plan

2016 | 385 | 621 | 1,721

2017 | 408 | 644 | 1,830

2018 | 407 | 686 | 1,974

Rate 3 (Chronic Kidney Disease)

YEAR | N Plans | Median Denominator Size per plan | Mean Denominator Size per plan

2016 | 344 | 348 | 895

2017 | 369 | 347 | 919

2018 | 377 | 365 | 998

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.

Section 1b.2 references data from the most recent three years of measurement for this measure. The data in section 1b.2 includes percentiles, mean, interquartile range and standard deviation and demonstrates room for improvement.

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 maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

HEDIS data are stratified by type of insurance (e.g., Commercial, Medicaid, Medicare). While not specified in the measure, this measure can also be stratified by demographic variables, such as race/ethnicity or socioeconomic status, in order to assess the presence of health care disparities, if the data are available to a plan. NCQA is actively engaged with partners including the CMS Office of Minority Health in identifying feasible methods to further integrate social risk factors into health plan quality measures, with a focus on stratification. Our work is aligned with recent recommendations from MedPAC and ASPE on optimal methods for addressing social risk in quality measurement and programs.^{1,2} This is an NCQA wide initiative. Our intent is to implement methods to bridge data concerns in the future.

HEDIS includes two measures that can be used as tools for assessing race/ethnicity and language needs of a plan’s population: Race/Ethnicity Diversity of Membership and the Language Diversity of Membership. These measures promote standardized methods for collecting these data and follow Office of Management and Budget and National Academy of Medicine guidance for collecting and categorizing race/ethnicity and language data. In addition, NCQA’s Multicultural Health Care Distinction Program outlines standards for collecting, storing, and using race/ethnicity and language data to assess health care disparities.

1. Medicare Payment Advisory Commission. (2020). The Medicare Advantage program: Status report. In Report to the Congress: Medicare Payment Policy (p. 397). http://medpac.gov/docs/default-source/reports/mar20_medpac_ch13_sec.pdf

2. Office of the Assistant Secretary for Planning and Evaluation, & U.S. Department of Health & Human Services. (2020). Second Report to Congress on Social Risk and Medicare’s Value-Based Purchasing Programs. <https://aspe.hhs.gov/social-risk-factors-and-medicare-value-based-purchasing-programs>

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

While disparities for this measure have not been well studied, there is some evidence to suggest differences in the use of potentially inappropriate medications by gender, race, and income status. A cross-sectional study examining the prevalence of potentially inappropriate medications in community-dwelling Medicare beneficiaries in California found that use was significantly higher in women, White beneficiaries, and low-income beneficiaries (Patel et al., 2018). A retrospective cohort study of 966,000 men and women treated by the Veteran's Health Administration showed that women were more likely than men to receive medications that may have harmful interactions with chronic conditions as described by the Beers Criteria (Bierman et al., 2007). In a different study, a retrospective database analysis of HEDIS data from the Department of Veterans Affairs found that Hispanics and those with no copayments had higher rates of medications listed as potentially harmful than Whites or those with required copayments (Pugh, 2011).

Bierman, A.S., M.J.V. Pugh, I. Dhalla, M. Amuan, B.G. Fincke, A. Rosen, D.R. Berlowitz. 2007. "Sex differences in inappropriate prescribing among elderly veterans." *The American Journal of Geriatric Pharmacotherapy*, 5(2):147-161.

Patel, R., L. Zhu, D. Sohal, E. Lenkova, N. Koshki, J. Woelfel, ... and E.L. Rogan. 2018. "Use of 2015 Beers Criteria Medications by Older Medicare Beneficiaries." *The Consultant Pharmacist* 33(1), 48–54.

Pugh, Mary Jo V., et al. "Exposure to Potentially Harmful Drug–Disease Interactions in Older Community-Dwelling Veterans Based on the Healthcare Effectiveness Data and Information Set Quality Measure: Who Is at Risk?" *Journal of the American Geriatrics Society* 59.9 (2011): 1673-1678.

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 sub criteria 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):

Safety : Medication

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly, Populations at Risk, Populations at Risk : Dual eligible beneficiaries, Populations at Risk : Individuals with multiple chronic conditions

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.)

N/A

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: 2993_DDE_Fall_2020_Value_Sets.xlsx

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

Yes

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

Since the last endorsement, the measure name was revised to replace the term “elderly” with “older adults” to align with the language used in the American Geriatrics Society (AGS) Beers Criteria. The list of medications used in this measure has been updated to reflect the most current recommendations included in the AGS 2019 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. A new exclusion for major depressive disorder was added to the History of Falls rate with the addition of SNRIs to the measure indicator. The AGS Beers Criteria recommend avoiding SNRIs for people with a history of falls, and avoiding nearly all antidepressants (SSRIs, tricyclics, SNRIs) is now recommended. We exclude members with a diagnosis of major depressive disorder from the rate because the benefits of using antidepressants for these individuals may outweigh the risks. We also removed Numerator 4 (total rate).

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) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Numerator 1: Patients with a history of falls who received at least one potentially harmful medication from Table DDE-A or Table DDE-B

Numerator 2: Patients with a diagnosis of dementia who received at least one potentially harmful medication from Table DDE-D

Numerator 3: Patients with chronic kidney disease who received at least one potentially harmful medication from Table DDE-E

S.5. 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, time period for data collection, 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 (S.14).

Rate 1 numerator: Dispensed an ambulatory prescription for an anticonvulsant, SSRI, or SNRI (Table DDE-A), or antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant (Table DDE-B) on or between the index episode start date (IESD) and December 31 of the measurement year.

Rate 2 numerator: Dispensed an ambulatory prescription for an antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant (Table DDE-B), or anticholinergic agent (Table DDE-D) on or between the IESD and December 31 of the measurement year.

Rate 3 numerator: Dispensed an ambulatory prescription for a Cox-2 selective NSAID or nonaspirin NSAID (Table DDE-E) on or between the IESD and December 31 of the measurement year.

Note: Do not include denied claims.

Index Episode Start Date. The earliest diagnosis, procedure or prescription between January 1 of the year prior to the measurement year and December 1 of the measurement year.

For an outpatient claim/encounter, the IESD is the date of service.

For an inpatient claim/encounter, the IESD is the discharge date.

For an acute inpatient encounter identified only by a professional claim (where the discharge date cannot be determined), the IESD is the date of service.

For dispensed prescriptions, the IESD is the dispense date.

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Table DDE-A: Potentially Harmful Drugs – Rate 1

Anticonvulsants:

Carbamazepine, Clobazam, Divalproex sodium, Ethosuximide, Ethotoin, Ezogabine, Felbamate, Fosphenytoin, Gabapentin, Lacosamide, Lamotrigine, Levetiracetam, Methsuximide, Oxcarbazepine, Phenobarbital, Phenytoin, Pregabalin, Primidone, Rufinamide, Tiagabine HCL, Topiramate, Valproate sodium, Valproic acid, Vigabatrin, Zonisamide

SNRIs:

Desvenlafaxine, Duloxetine, Levomilnacipran, Venlafaxine

SSRIs:

Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Setraline

Table DDE-B: Potentially Harmful Drugs – Rate 1 (History of Falls) and Rate 2 (Dementia)

Antipsychotics:

Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Chlorpromazine, Clozapine, Fluphenazine, Haloperidol, Iloperidone, Loxapine, Lurasidone, Molindone, Olanzapine, Paliperidone, Perphenazine, Pimozide, Quetiapine, Risperidone, Thioridazine, Thiothixene, Trifluoperazine, Ziprasidone

Benzodiazepine hypnotics:

Alprazolam, Chlordiazepoxide products, Clonazepam, Clorazepate-Dipotassium, Diazepam, Estazolam, Flurazepam HCL, Lorazepam, Midazolam HCL, Oxazepam, Quazepam, Temazepam, Triazolam

Nonbenzodiazepine hypnotics:

Eszopiclone, Zaleplon, Zolpidem

Tricyclic antidepressants:

Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6 mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine

Table DDE-D: Potentially Harmful Drugs – Rate 2 (Dementia)

Anticholinergic agents, antiemetics:

Prochlorperazine, Promethazine

Anticholinergic agents, antihistamines:

Brompheniramine, Carbinoxamine, Chlorpheniramine, Hydroxyzine, Clemastine, Cyproheptadine, Pyrilamine, Triprolidine, Dimenhydrinate, Diphenhydramine, Meclizine, Dexbrompheniramine, Dexchlorpheniramine, Doxylamine

Anticholinergic agents, antispasmodic:

Atropine, Homatropine, Belladonna alkaloids, Dicyclomine, Hyoscyamine, Methscopolamine, Propantheline, Scopolamine, Clidinium-chlordiazepoxide

Anticholinergic agents, antimuscarinics (oral)

Darifenacin, Fesoterodine, Solifenacin, Trosipium, Flavoxate, Oxybutynin, Tolterodine

Anticholinergic agents, anti-Parkinson agents

Benzotropine, Trihexyphenidyl

Anticholinergic agents, skeletal muscle relaxants

Cyclobenzaprine, Orphenadrine

Anticholinergic agents, SSRIs:

Paroxetine

Anticholinergic agents, antiarrhythmic:
Disopyramide

Table DDE-E: Cox-2 Selective NSAIDs and Nonasprin NSAIDs

Cox-2 Selective NSAIDs:

Celecoxib

Nonaspirin NSAIDs:

Diclofenac potassium, Diclofenac sodium, Etodolac, Fenoprofen, Flurbiprofen, Ibuprofen, Indomethacin, Ketoprofen, Ketorolac, Meclofenamate, Mefenamic acid, Meloxicam, Nabumetone, Naproxen, Naproxen sodium, Oxaprozin, Piroxicam, Sulindac, Tolmetin

S.6. Denominator Statement *(Brief, narrative description of the target population being measured)*

All patients 65 years of age and older with a history of falls, dementia or chronic kidney disease in the measurement year or the year prior to the measurement year.

S.7. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, 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 target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

All patients ages 67 years and older as of December 31 of the measurement year with a history of falls, dementia or chronic kidney disease. Each of the three rates in the measure has a different denominator:

Rate 1 denominator: Patients with an accidental fall or hip fracture (Note: hip fractures are used as a proxy for identifying accidental falls). Individuals with either of the following on or between January 1 of the year prior to the measurement year and December 1 of the measurement year meet criteria:

-An accidental fall (Falls Value Set).

-An acute inpatient encounter (Acute Inpatient Value Set), nonacute inpatient encounter (Nonacute Inpatient Value Set), outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) with a hip fracture (Hip Fractures Value Set).

-An acute or nonacute inpatient discharge with a hip fracture (Hip Fractures Value Set). To identify acute and nonacute inpatient discharges: 1) Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2) Identify the discharge date for the stay. 3) Identify the index episode start date (IESD) for each patient.

Rate 2 denominator: Patients with a diagnosis of dementia (Dementia Value Set) or a dispensed dementia medication (Table DDE-C) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Identify the IESD for each patient.

Rate 3 denominator: Patients with chronic kidney disease as identified by a diagnosis of ESRD (ESRD Value Set), dialysis (Dialysis Procedure Value Set), stage 4 chronic kidney disease (CKD Stage 4 Value Set), nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.

Note: Patients with more than one disease or condition may appear in the measure multiple times (i.e., in each indicator for which they qualify).

Index Episode Start Date. The earliest diagnosis, procedure or prescription between January 1 of the year prior to the measurement year and December 1 of the measurement year.

For an outpatient claim/encounter, the IESD is the date of service.

For an inpatient claim/encounter, the IESD is the discharge date.

For an acute inpatient encounter identified only by a professional claim (where the discharge date cannot be determined), the IESD

is the date of service.
For dispensed prescriptions, the IESD is the dispense date.

See S.2.b for all Value Sets

Table DDE-C: Prescriptions to Identify Members with Dementia

Cholinesterase inhibitors:

Donepezil, Galantamine, Rivastigmine

Miscellaneous central nervous system agents:

Memantine

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

For those who meet denominator criteria for the history of falls rate (Rate 1): exclude those with a diagnosis of psychosis, schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder or seizure disorder.

For those who meet denominator criteria for the dementia rate (Rate 2): exclude those with a diagnosis of psychosis, schizophrenia, schizoaffective disorder or bipolar disorder.

S.9. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, 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 those who meet denominator criteria for the history of falls rate (Rate 1): Exclude patients with a diagnosis of psychosis (Psychosis Value Set), schizophrenia, schizoaffective disorder (Schizophrenia Value Set), bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set), major depressive disorder (Major Depression or Dysthymia Value Set) or seizure disorder (Seizure Disorders Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.

For those who meet denominator criteria for the dementia rate (Rate 2): Exclude patients with a diagnosis of psychosis (Psychosis Value Set), schizophrenia, schizoaffective disorder (Schizophrenia Value Set) or bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.

S.10. Stratification Information *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – 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.)*

No risk adjustment or risk stratification

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. 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 = Lower score

S.14. Calculation Algorithm/Measure Logic *(Diagram or 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; time period for data, aggregating data; risk adjustment; etc.)*

Step 1. Determine the eligible population: All patients 67 years of age and older as of the end (i.e., December 31) of the measurement year.

Step 2: Identify the denominators for each of the three rates:

Rate 1: Those in the eligible population with a history of falls (see S.7 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Exclude patients with a diagnosis of psychosis, schizophrenia, bipolar disorder, major depressive disorder, or seizure disorder (see S.9 for details). Identify the index episode start date (IESD) for each patient.

Rate 2: Those in the eligible population with dementia (see S.7 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Exclude patients with a diagnosis of psychosis, schizophrenia, or bipolar disorder (see S.9 for details). Identify the IESD for each patient.

Rate 3: Those in the eligible population with chronic kidney disease (see S.7 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Identify the IESD for each patient.

Step 3: Identify the numerators: Individuals in each of the denominators who have received at least one potentially harmful medication on or after the IESD (see definitions of potentially harmful medications for each numerator in section S.5).

Step 4: Calculate the rates:

Rate 1 – Numerator 1 divided by denominator 1.

Rate 2 – Numerator 2 divided by denominator 2.

Rate 3 – Numerator 3 divided by denominator 3.

Note: For this measure, a lower rate indicates better performance for all three rates.

Index Episode Start Date. The earliest diagnosis, procedure or prescription between January 1 of the year prior to the measurement year and December 1 of the measurement year.

For an outpatient claim/encounter, the IESD is the date of service.

For an inpatient claim/encounter, the IESD is the discharge date.

For an acute inpatient encounter identified only by a professional claim (where the discharge date cannot be determined), the IESD is the date of service.

For dispensed prescriptions, the IESD is the dispense date.

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

N/A

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

N/A

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Health Plan

S.21. Care Setting (Check *ONLY* the settings for which the measure is SPECIFIED AND TESTED)

Outpatient Services

If other:

S.22. 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.)

N/A

2. Validity – See attached Measure Testing Submission Form

[DDE_2993_Testing_Form-637396682473177598.docx](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

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 or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

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) Update this field for **maintenance of endorsement**.

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. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

N/A

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. Please also complete and attach the NQF Feasibility Score Card.

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. Required for maintenance of endorsement. Describe difficulties (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 instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

NCQA recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may vary, and other errors may taint the results, diminishing the usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO's ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.

The HEDIS Compliance Audit addresses the following functions:

- 1) information practices and control procedures
- 2) sampling methods and procedures
- 3) data integrity
- 4) compliance with HEDIS specifications
- 5) analytic file production
- 6) reporting and documentation

In addition to the HEDIS Audit, NCQA provides a system to allow "real-time" feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this system NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measure. This system is vital to the regular re-evaluation of NCQA measures.

Input from NCQA auditing and the Policy Clarification Support System informs the annual updating of all HEDIS measures including updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence. During re-evaluation information from NCQA auditing and Policy Clarification Support System is used to inform evaluation of the scientific soundness and feasibility of the 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).

Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

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.

| Specific Plan for Use | Current Use (for current use provide URL) |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | <p>Public Reporting Health Plan Rating http://www.ncqa.org/ReportCards/HealthPlans/HealthInsurancePlanRankings/HealthPlanRatingsPreview.aspx Annual State of Health Care Quality http://www.ncqa.org/tabid/836/Default.aspx Health Plan Rating http://www.ncqa.org/ReportCards/HealthPlans/HealthInsurancePlanRankings/HealthPlanRatingsPreview.aspx Annual State of Health Care Quality http://www.ncqa.org/tabid/836/Default.aspx</p> <p>Regulatory and Accreditation Programs HEDIS®-Health Plan http://www.ncqa.org/Programs/Accreditation/HealthPlanHP.aspx HEDIS®-ACO http://www.ncqa.org/Programs/Accreditation/AccountableCareOrganizationACO.aspx</p> <p>HEDIS®-Health Plan http://www.ncqa.org/Programs/Accreditation/HealthPlanHP.aspx HEDIS®-ACO http://www.ncqa.org/Programs/Accreditation/AccountableCareOrganizationACO.aspx</p> <p>Quality Improvement (external benchmarking to organizations) NCQA Quality Compass https://www.ncqa.org/programs/data-and-information-technology/data-purchase-and-licensing/quality-compass/</p> |

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

HEALTH PLAN RATINGS/REPORT CARDS: This measure is used to calculate health plan ratings which are reported on the NCQA website. These ratings are based on performance on HEDIS measures among other factors. In 2019, a total of 255 Medicare health plans, 515 commercial health plans and 188 Medicaid health plans across 50 states were included in the rankings.

STATE OF HEALTH CARE ANNUAL REPORT: This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2019, the report included results from calendar year 2018 for health plans covering a record 136 million people, or 43 percent of the U.S. population.

QUALITY COMPASS: This measure is used in Quality Compass which is an indispensable tool used for selecting a health plan, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

HEALTH PLAN ACCREDITATION: This measure is used in scoring for accreditation of Medicare Advantage Health Plans. In 2019, a total of 247 Medicare Advantage health plans were accredited using this measure among others. Health plans are scored based on performance compared to benchmarks.

HEDIS ACCOUNTABLE CARE ORGANIZATION ACCREDITATION: This measure is used in NCQA's ACO Accreditation program, that helps health care organizations demonstrate their ability to improve quality, reduce costs and coordinate patient care. ACO standards and guidelines incorporate whole-person care coordination throughout the health care system.

4a1.2. 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?)

N/A

4a1.3. 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.)

N/A

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

Health plans that report HEDIS measures calculate their rates and know their performance when submitting to NCQA. NCQA publicly reports rates across all plans and also creates benchmarks in order to help plans understand how they perform relative to other plans. Public reporting and benchmarking are effective quality improvement methods.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual HEDIS Update and Best Practices Conference, NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly. NCQA also regularly provides technical assistance on measures through its Policy Clarification Support System, as described in Section 3c1.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

NCQA measures are evaluated regularly. During this "reevaluation" process, we seek broad input on the measure, including input on performance and implementation experience. We use several methods to obtain input, including vetting of the measure with several multi-stakeholder advisory panels, public comment posting, and review of questions submitted to the Policy Clarification Support System. This information enables NCQA to comprehensively assess a measure's adherence to the HEDIS Desirable Attributes of Relevance, Scientific Soundness and Feasibility.

4a2.2.2. Summarize the feedback obtained from those being measured.

In general, health plans have not reported significant barriers to implementing this measure, as it uses the administrative data collection method. Questions received through the Policy Clarification Support system have generally centered around minor clarification of the specifications, such as confirmation that information in claims meets the measure intent and satisfies the measure numerator as well as questions about the index episode start date (IESD). NCQA responded to all questions to ensure consistent implementation of the specifications. During a recent public comment period, a majority of comments from measured entities supported updates to the measure to align with the latest clinical recommendations.

4a2.2.3. Summarize the feedback obtained from other users

This measure has been deemed a priority measure by NCQA, as illustrated by its use in programs such as Health Plan Rating, NCQA Accreditation and Quality Compass. States, employers, and regional health quality organizations value this measure (and other HEDIS measures) for shining a light on quality.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

During the measure's last major update, feedback obtained through the mechanisms described in 4a2.2.1 informed how we revised the measure specification to include clarifying text to further support determining numerator compliance.

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.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (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.)

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.

The data demonstrate variation in all three rates of the measure (see section 1b.2 for summary of data from health plans). For 2018, 48.7 percent of individuals with a history of falls received at least one high-risk medication. Among individuals with dementia, 45.5 percent received at least one high-risk medication and among those with chronic kidney disease, 10.2 percent received at least one high-risk medication. Overall, rates from 2016 to 2018 showed relatively stable performance, yet the 2018 rates still suggest significant room for improvement in medication safety for older adults, particularly for the history of falls and dementia rates. For all rates there is a sizeable gap between the plans at the 10th percentile and 90th percentile, demonstrating a persistent gap in care between the best and worst performing health plans.

4b2. 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).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

There were no identified unintended consequences for this measure during testing or since implementation. If this measure were to be implemented poorly, there is concern that it could lead to reduced access to medications. There will always be individual cases that will warrant the use of a potentially harmful medication. For example, antidepressants are listed as potentially harmful to patients at risk for falls, however, clinicians should weigh the relative risk of increased falls against the potential benefit of the use of antidepressants for those with severe depression.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

There were no identified unexpected findings during testing or since implementation of this measure.

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)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

0022: Use of High-Risk Medications in Older Adults (DAE)

5a. Harmonization of Related Measures

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 harmonized to the extent possible?

No

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

The Use of High-Risk Medications in Older Adults (DAE) measure and NQF 2993 have a similar focus (measuring potentially inappropriate medication use in older adults) and reporting level (health plan), however they have different target populations. The DAE measure targets a larger population of all older adults and assesses use of high-risk medications that have been recommended to be avoided in all older adults. This measure (NQF 2993) targets patients with a specific condition or disease who can experience adverse effects when combined with certain medications that are recommended to be avoided for that condition. The DAE measure (NQF 0022) is being submitted for NQF re-endorsement during this current Patient Safety project as well. Together these measures cover a significant portion of the AGS Beers Criteria recommendations for population-level medication safety assessment.

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.)

N/A

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.

No appendix Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): National Committee for Quality Assurance

Co.2 Point of Contact: Bob, Rehm, nqf@ncqa.org, 202-955-1728-

Co.3 Measure Developer if different from Measure Steward: [National Committee for Quality Assurance](#)

Co.4 Point of Contact: [Bob, Rehm, \[nqf@ncqa.org\]\(mailto:nqf@ncqa.org\), 202-955-1728-](#)

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.

Geriatric Measurement Advisory Panel (GMAP):

Wade Aubry, University of California, San Francisco

Arlene Bierman, Agency for Healthcare Research and Quality (AHRQ)

Patricia Bomba, Excellus BlueCross BlueShield

Nicole Brandt, University of Maryland, School of Pharmacy

Jennie Chin Hansen, Geriatric Expert

Joyce Dubow, Consumer Representative

Pete Hollmann, Brown Medicine

Jeffrey Kelman, Department of Health and Human Services

Karen Nichols, Trinity-Health PACE

Steven Phillips, Geriatric Specialty Care

Erwin Tan, American Association of Retired Persons (AARP)

Eric G Tangelos, Mayo Clinic

Dirk Wales, Axial Healthcare

Joan Weiss, Health Resources and Services Administration

Neil Wenger, University of California, Los Angeles

Committee on Performance Measurement (CPM):

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Elizabeth Drye, MD, SM, Yale School of Medicine

Andrea Gelzer, MD, MS, FACP, AmeriHealth Caritas

Kate Goodrich, MD, MHS, Centers for Medicare & Medicaid Services

David Grossman, MD, MPH, Washington Permanente Medical Group

Christine Hunter, (Co-Chair), MD, Independent Board Director

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Jeff Kelman, MMSc, MD, Department of Health and Human Services

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Rodolfo Saenz, MD, MMM, FACOG, Riverside Medical Clinic

Marcus Thygeson, (Co-Chair), MD, MPH, Bind Benefits

JoAnn Volk, MA, Georgetown University

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: 07, 2019

Ad.4 What is your frequency for review/update of this measure? Approximately every 3 years, sooner if the clinical guidelines have changed significantly.

Ad.5 When is the next scheduled review/update for this measure? 12, 2021

Ad.6 Copyright statement: ©2020 by the National Committee for Quality Assurance

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Washington, DC 20005

Ad.7 Disclaimers: 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.

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Ad.8 Additional Information/Comments: NCQA Notice of Use. Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, “commercial use” refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

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