THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0
August 2008

The measure information you submit will be shared with NQF's Steering Committees and Technical Advisory Panels to evaluate measures against the NQF criteria of importance to measure and report, scientific acceptability of measure properties, usability, and feasibility. Four conditions (as indicated below) must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards. Not all acceptable measures will be strong—or equally strong—among each set of criteria. The assessment of each criterion is a matter of degree; however, all measures must be judged to have met the first criterion, importance to measure and report, in order to be evaluated against the remaining criteria. References to the specific measure evaluation criteria are provided in parentheses following the item numbers. Please refer to the *Measure Evaluation Criteria* for more information at *www.qualityforum.org* under Core Documents. Additional guidance is being developed and when available will be posted on the NQF website.

Use the tab or arrow (↓→) keys to move the cursor to the next field (or back ←↑). There are three types of response fields:

- drop-down menus - select one response;
- check boxes – check as many as apply; and
- text fields – you can copy and paste text into these fields or enter text; these fields are not limited in size, but in most cases, we ask that you summarize the requested information.

Please note that URL hyperlinks do not work in the form; you will need to type them into your web browser.

Be sure to answer all questions. Fields that are left blank will be interpreted as no or none. Information must be provided in this form. Attachments are not allowed except when specifically requested or to provide additional detail or source documents for information that is summarized in this form. If you have important information that is not addressed by the questions, they can be entered into item #48 near the end of the form.

For questions about this form, please contact the NQF Project Director listed in the corresponding call for measures.

	CONDITIONS FOR CONSIDERATION BY NQF
	Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards.
A (A)	*Public domain or Intellectual Property Agreement signed: IP Agreement signed and submitted (If no, do not submit)* *Template for the Intellectual Property Agreement is available at www.qualityforum.org under Core Documents.*
B (B)	*Measure steward/maintenance: Is there an identified responsible entity and process to maintain and update the measure on a schedule commensurate with clinical innovation, but at least every 3 years? Yes, information provided in contact section (If no, do not submit)*
C (C)	*Intended use: Does the intended use of the measure include BOTH public reporting AND quality improvement? Yes (If no, do not submit)*
D (D)	*Fully developed and tested: Is the measure fully developed AND tested? Yes, fully developed and tested (If not tested and no plans for testing within 24 months, do not submit)*

THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0
August 2008

	(for NQF staff use) NQF Review #: *EC-007-08* NQF Project: *National Voluntary Consensus Standards for Ambulatory Care Using Clinically Enriched Administrative Data*
	MEASURE SPECIFICATIONS & DESCRIPTIVE INFORMATION
1	*Information current as of (date- MM/DD/YY): 11/21/08 - revised 3/25/09*
2	*Title of Measure: Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy*
3	**Brief description of measure [1]:** To ensure that all eligible members who have been newly diagnosed and resected with colorectal cancer receive a follow-up colonoscopy within 15 months of resection.
4 (2a)	**Numerator Statement:** Members receiving a colonoscopy or sigmoidoscopy as appropriate during the 15 months after the index date. Note: Index date is defined as the first instance of denominator criterion A. **Time Window:** The 15 months after the index date. **Numerator Details** (Definitions, codes with description): Numerator logic: A or B [A] Members who received a colonoscopy during the 0-15 months after the index date. Colonoscopy: CPT-4 code(s): 3017F,44388-44394, 44397, 45378-45387, 45391, 45392 HCPCS code(s): G0105, G0121 ICD-9 surgical proc code(s): 45.22, 45.23, 45.25,45.42, 45.43 [B] Members who received a sigmoidoscopy during the 0-15 months after the index date. Sigmoidoscopy: CPT-4 code(s): 45330-45335, 45337, 45338-45342, 45345 HCPCS code(s): G0104 ICD-9 surgical proc code(s): 45.24
5 (2a)	**Denominator Statement:** Continuously enrolled members who are status post resection of colorectal cancer during the year ending 15 months prior to the measurement year. **Time Window:** The one year period ending 15 months prior to the measurement year.

[1] Example of measure description: Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year.

	Denominator Details (Definitions, codes with description): Denominator logic: A and B and CE [A] Partial colectomy or proctectomy during the year ending 15 months prior to the end of the measurement year. Partial Colectomy or Proctectomy CPT-4 code(s): 44139-44141, 44143-44147, 44160, 44204-44208, 44213, 45110-45114, 45116, 45119, 45123, 45126, 45160, 45170, 45395, 45397 ICD-9 surgical proc code(s): 45.4x, 45.7x, 48.35, 48.36, 48.4x, 48.5, 48.6x, 48.8x [B] Diagnosis of colorectal cancer on the same date of service as the index date. Colorectal Cancer ICD-9 diagnosis code(s): 153.0-153.4, 153.6-153.9 154.0, 154.1, 154.8, V10.00, V10.05, V10.06 [CE] Members continuously enrolled during the 0-15 months after the index date. Note: Index date is defined as the first instance of denominator criterion A or B. Note: Denominator criteria([A] or [B]) are required to occur on the same date of service as denominator criterion [C].
6 (2a, 2d)	**Denominator Exclusions:** Members who are status post resection of colon cancer any time prior to the index date, or members who were in hospice care 0 to 15 months after the index date. Note: Index date is defined as the first instance of denominator criterion A. **Denominator Exclusion Details** (Definitions, codes with description): Denominator exclusion criteria: (A and B) or C [A] Members with a diagnosis of colorectal cancer any time prior to the index date. Colorectal Cancer: ICD-9 diagnosis code(s): 153.0-153.4, 153.6-153.9 154.0, 154.1, 154.8, V10.00, V10.05, V10.06 [B] Members who had prior resection of colon prior to the index date. Resection of Colon or Rectum: CPT-4 code(s): 44139-44141, 44143-44147, 44150, 44151, 44160, 44204-44208, 44210, 45110-45114, 45116, 45119, 45123, 45126, 45160, 45170, 45395, 45397 ICD-9 surgical proc code(s): 45.4x, 45.7x, 45.8, 48.35, 48.36, 48.4x, 48.5, 48.6x, 48.8x [C] Members who were in hospice care 0 to 15 months after the index date. Hospice Care: ICD-9 diagnosis code(s): V66.7 CPT-4 code(s): 99376*, 99377, 99378 HCPCS code(s): G0065*, G0182, G0337, Q5001-Q5009, S0255, S0271, S9126, T2042-T2046 UB revenue code(s): 0115, 0125, 0135, 0145, 0155, 0235, 0650-0652, 0655-0659 UB type of bill code(s): 81x, 82x Place of service code(s): 34 *Code range expired, but still appropriate for retrospective analysis
7 (2a, 2h)	**Stratification** Do the measure specifications require the results to be stratified? No ► If "other" describe: **Identification of stratification variable(s):**

	Stratification Details (Definitions, codes with description):
8 (2a, 2e)	**Risk Adjustment** Does the measure require risk adjustment to account for differences in patient severity before the onset of care? No ► **If yes,** (select one) ► Is there a separate proprietary owner of the risk model? (select one) **Identify Risk Adjustment Variables:** **Detailed risk model:** attached ☐ **OR** Web page URL:
9 (2a)	**Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☐ **OR** Web page URL: **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 ► If "Other", please describe:
10 (2a. 4a, 4b)	**Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** **Data dictionary/code table** attached ☒ **OR** Web page URL: **Data Quality** (2a) *Check all that apply* ☐ Data are captured from an authoritative/accurate source (e.g., lab values from laboratory personnel) ☒ Data are coded using recognized data standards ☐ Method of capturing data electronically fits the workflow of the authoritative source ☐ Data are available in EHRs ☐ Data are auditable
11 (2a, 4b)	**Data Source and Data Collection Methods** *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply* ☐ Electronic Health/Medical Record ☐ Electronic Clinical Database, Name: ☐ Electronic Clinical Registry, Name: ☒ Electronic Claims ☐ Electronic Pharmacy data ☐ Electronic Lab data ☒ Electronic source – other, Describe: Member demographics and member enrollment data ☐ Paper Medical Record ☐ Standardized clinical instrument, Name: ☐ Standardized patient survey, Name: ☐ Standardized clinician survey, Name: ☐ Other, Describe: Instrument/survey attached ☐ **OR** Web page URL:
12 (2a)	**Sampling** *If measure is based on a sample, provide instructions and guidance on sample size.* **Minimum sample size:** N/A **Instructions:** N/A
13 (2a)	**Type of Measure:** Process ► If "Other", please describe: ► If part of a composite or paired with another measure, please identify composite or paired measure
14 (2a)	**Unit of Measurement/Analysis** (*Who or what is being measured*) *Check all that apply.* ☐ Can be measured at all levels ☒ Individual clinician (e.g., physician, nurse) ☒ Group of clinicians (e.g., facility department/unit, group practice) ☐ Facility (e.g., hospital, nursing home) ☐ Integrated delivery system ☒ Health plan ☒ Community/Population ☐ Other (*Please describe*):
15 (2a)	**Applicable Care Settings** *Check all that apply* ☐ Can be used in all healthcare settings ☒ Ambulatory Care (office/clinic) ☐ Behavioral Healthcare ☐ Community Healthcare ☐ Dialysis Facility ☐ Emergency Department ☐ Hospice ☐ Hospital ☐ Long term acute care hospital ☐ Nursing home/ Skilled Nursing Facility (SNF) ☐ Prescription Drug Plan ☐ Rehabilitation Facility

	☐ EMS emergency medical services ☐ Substance Use Treatment Program/Center ☒ Health Plan ☐ Other (*Please describe*): ☐ Home Health
	IMPORTANCE TO MEASURE AND REPORT
	Note: This is a threshold criterion. If a measure is not judged to be sufficiently important to measure and report, it will not be evaluated against the remaining criteria.
16 (1a)	**Addresses a Specific National Priority Partners Goal** *Enter the numbers of the specific goals related to this measure (see list of goals on last page)*: N/A
17 (1a)	**If not related to NPP goal, identify high impact aspect of healthcare** patient/societal consequences of poor quality **Summary of Evidence:** Surveillance for recurrent colorectal cancer assists in the removal of pre-malignant polyps and early detection of malignancy.[1] In patients with locally recurrent or anastomotic disease, a limited number of metastases involving liver or lung, metachronous (second primary) malignancies, or polyps are potentially curable with further surgery. In addition, incidence of metachronous cancer is higher in colorectal cancer patients status post resection compared with the general population, and incidence is highest in the first 24 months after surgery.[2-4] Colonoscopy surveillance may not only potentially detect these metachronous cancers at a surgically curable stage, but also prevent metachronous lesions by providing an opportunity for removing adenomatous polyps.[4] **Citations[2] for Evidence:** 1. Jeffery, G.M., B.E. Hickey, and P. Hider, Follow-up strategies for patients treated for non-metastatic colorectal cancer. Cochrane Database Syst Rev, 2002(1): p. CD002200. 2. Green, et al., Surveillance for second primary colorectal cancer after adjuvant chemotherapy: an analysis of Intergroup 0089. Ann Intern Med, 2002. 136(4): p. 261-9. 3. Barillari, et al., Surveillance of colorectal cancer: effectiveness of early detection of intraluminal recurrences on prognosis and survival of patients treated for cure. Dis Colon Rectum, 1996. 39(4): p. 388-93. 4. Brady, et al., Surveillance colonoscopy after resection for colon carcinoma. South Med J, 1990. 83(7): p. 765-8.
18 (1b)	**Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.* **Summary of Evidence:** Since 2000, colorectal cancer screening rates by colonoscopy have improved. Colonoscopy screening rates of the eligible population have increased from 20% in 2000 to 39.9% in 2005. However, current screening rates are far from optimal.[1, 2] Post-resection colonoscopy surveillance is recommended, but only 46% of patients undergo this surveillance within the first 14 months for recurrence.[3] **Citations for Evidence:** 1. Smith RA, Cokkinides V, Brawley O. Cancer Screening in the United States, 2008: A Review of Current American Cancer Society Guidelines and Cancer Screening Issues. CA Cancer J Clin 2008;58;161-179. 2. Sarfaty M, Wender R. How to increase colorectal cancer screening rates in practice. CA Cancer J Clin 2007;57:354–366. 3. Knopf KB, Warren JL, Feuer EJ, Brown ML. Bowel surveillance patterns after a diagnosis of colorectal cancer in Medicare beneficiaries. Gastrointestinal Endoscopy. 2001: 54(5);563-571.
19 (1b)	**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.* **Summary of Evidence:** Uninsured non-elderly adults are significantly less likely to be screened for colorectal cancer compared to older or insured adults. Furthermore, Hispanic persons were less likely to report colon cancer screening compared to non-Hispanic White or Black individuals.[1] However, there are no studies of racial ethnic disparity on post-resection colonoscopy surveillance.

[2] Citations can include, but are not limited to journal articles, reports, web pages (URLs).

	Citations for evidence: 1. Smith RA, Cokkinides V, Brawley O. Cancer Screening in the United States, 2008: A Review of Current American Cancer Society Guidelines and Cancer Screening Issues. CA Cancer J Clin 2008;58;161-179.
20 (1c)	**If measuring an Outcome** Describe relevance to the national health goal/priority, condition, population, and/or care being addressed: N/A **If not measuring an outcome, provide evidence supporting this measure topic and grade the strength of the evidence** *Summarize the evidence (including citations to source) supporting the focus of the measure as follows:* • Intermediate outcome – evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit. • Process – evidence that the measured clinical or administrative process leads to improved health/avoidance of harm and if the measure focus is on one step in a multi-step care process, it measures the step that has the greatest effect on improving the specified desired outcome(s). • Structure – evidence that the measured structure supports the consistent delivery of effective processes or access that lead to improved health/avoidance of harm or cost/benefit. • Patient experience – evidence that an association exists between the measure of patient experience of health care and the outcomes, values and preferences of individuals/ the public. • Access – evidence that an association exists between access to a health service and the outcomes of, or experience with, care. • Efficiency– demonstration of an association between the measured resource use and level of performance with respect to one or more of the other five IOM aims of quality. **Type of Evidence** *Check all that apply* ☒ Evidence-based guideline ☐ Quantitative research studies ☐ Meta-analysis ☐ Qualitative research studies ☐ Systematic synthesis of research ☐ Other (*Please describe*):

	Overall Grade for Strength of the Evidence[3] (*Use the USPSTF system, or if different, also describe how it relates to the USPSTF system*)**:** B **Summary of Evidence** (*provide guideline information below*)**:** Although no study was identified that shows a positive correlation with survival from colonoscopy surveillance alone, studies have shown a statistically significant impact on survival with intensive follow-up that included yearly colonoscopy.[1, 2] In two meta-analyses, patients who received intensive surveillance (using multi-component surveillance strategies which included colonoscopy) were less likely to have a recurrent cancer after 5 years than those who received less intensive surveillance.[3, 4] A third meta-analysis of 7 clinical trials involving a total of 2,293 patients with colorectal cancer undergoing curative resection also found significant reduction in overall mortality in patients who underwent intensive follow-up using colonoscopy (p=0.04).[5] A review of evidence found both an incidence rate of 0.7% two years following cancer resection and that the use of surveillance colonoscopy followed by surgery resulted in a cure for 87% of cancers found.[6] **Citations for Evidence:** 1. Cancer Facts and Figures 2006. [cited 2007 August 27]. 2. Desch, et al., Recommended colorectal cancer surveillance guidelines by the American Society of Clinical Oncology. J Clin Oncol, 1999. 17(4): p. 1312. 3. Jeffery, G.M., B.E. Hickey, and P. Hider, Follow-up strategies for patients treated for non-metastatic colorectal cancer. Cochrane Database Syst Rev, 2002(1): p. CD002200. 4. Renehan, A.G., et al., Impact on survival of intensive follow up after curative resection for colorectal cancer: systematic review and meta-analysis of randomised trials. Bmj, 2002. 324(7341): p. 813. 5. Tjandra, J.J. and M.K. Chan, Follow-up after curative resection of colorectal cancer: a meta-analysis. Dis Colon Rectum, 2007. 50(11): p. 1783-99. 6. Rex, D.K., et al., Guidelines for Colonoscopy Surveillance after Cancer Resection: A Consensus Update by the American Cancer Society and US Multi-Society Task Force on Colorectal Cancer. CA Cancer J Clin, 2006. 56(3): p. 160-167.
21 (1c)	**Clinical Practice Guideline** *Cite the guideline reference; quote the specific guideline recommendation related to the measure and the guideline author's assessment of the strength of the evidence; and summarize the rationale for using this guideline over others.* **Guideline Citation:** 1. Desch, C.E., et al., Colorectal cancer surveillance: 2005 update of an American Society of Clinical Oncology practice guideline. J Clin Oncol, 2005. 23(33): p. 8512-9. 2. Ko, C. and N.H. Hyman, Practice parameter for the detection of colorectal neoplasms: an interim report (revised). Dis Colon Rectum, 2006. 49(3): p. 299-301. 3. NCCN. Clinical Practice Guidelines in Oncology: Colon Cancer. 2005 [cited 2005 June 16]; Available from: http://www.nccn.org/professionals/physician_gls/PDF/colon.pdf. 4. Rex, D.K., et al., Guidelines for Colonoscopy Surveillance after Cancer Resection: A Consensus Update by the American Cancer Society and US Multi-Society Task Force on Colorectal Cancer. CA Cancer J Clin, 2006. 56(3): p. 160-167. 5. Davila, et al., ASGE guideline: colorectal cancer screening and surveillance. Gastrointest Endosc, 2006. 63(4): p. 546-57. **Specific guideline recommendation:** • In 2005, The American Society of Clinical Oncology (ASCO), citing an older 2003 American Gastroenterology Association (AGA) surveillance guideline, recommended that patients with resection for

[3]The strength of the body of evidence for the specific measure focus should be systematically assessed and rated, e.g., USPSTF grading system www.ahrq.gov/clinic/uspstmeth.htm: A - The USPSTF recommends the service. There is high certainty that the net benefit is substantial. B - The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. C - The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. Offer or provide this service only if other considerations support the offering or providing the service in an individual patient. D - The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. I - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

	colorectal cancer should have a repeat colonoscopy 3 years after operative treatment and that patients with rectal cancer who had not been treated with pelvic radiation should have flexible proctosigmoidoscopy every 6 months for 5 years.[1] Of note, subsequently, AGA updated their guideline to recommend repeat colonoscopy for colorectal patients after resection in 1 year post resection. • In 2006, the American Society of Colon and Rectal Surgeons recommended that colonoscopy should be performed 3 years after resection, and if normal, followed by colonoscopy every 5 years. [2] Of note, this guideline was referencing an old 2003 guideline published by US Multi-Society Task Force on Colorectal Cancer, which updated its recommendation in 2006 to colonoscopy within 1 year for colorectal patients after resection. • The National Comprehensive Cancer Network (NCCN) recommends that all patients with non-metastatic colon cancer, or colon cancer with resectable synchronous liver or lung metastases should have a colonoscopy 1 year after their initial resection. If the results are normal, NCCN recommends a repeat colonoscopy in 3 years and then every 5 years thereafter. If the colonoscopy at 1 year is abnormal, then NCCN recommends a repeat colonoscopy in 1 year.[3] • In 2006, in a consensus guideline endorsed by the AGA, the American Society for Gastrointestinal Endoscopy, the American Cancer Society (ACS) and the US Multi-Society Task Force on Colorectal Cancer together recommended that patients undergoing curative resection for colorectal cancer should undergo a colonoscopy 1 year after the resection and if normal, then repeat colonoscopy can be performed every 3 to 5 years.[4] • In 2006 the American Society for Gastrointestinal Endoscopy recommended that surveillance colonoscopy be performed 1 year after surgical resection of colon cancer, and if normal, again in 3 years. If the repeat colonoscopy is normal, then the patient should undergo repeat colonoscopy in 5 years.[5] **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)*: N/A **Rationale for using this guideline over others:** Societies contributing to the guidelines cited above are highly regarded organizations whose guidelines are well respected within the medical community.
22 (1c)	**Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations*. **Summary:** Although there is little controversy regarding the value and efficacy of colonoscopy screening after colon resection, colonoscopy screening can result in serious side effects. Out of every 10,000 colonoscopies, there are 34 perforations and 6.7 serious bleeds, even in well-equipped centers where procedures are performed by experts.[1] **Citations:** 1. Ladouceur R. Why does this controversy still exist? Can Fam Physician 2008;54(4):493.
23 (1)	**Briefly describe how this measure (as specified) will facilitate significant gains in healthcare quality related to the specific priority goals and quality problems identified above:** By recommending colonoscopy within 15 months of resection for colorectal cancer, patients with recurrent or metachronous disease will be identified and offered treatment. Given that the rate of this type of surveillance was less than 50% in 2001, there is much room for improvement. By detecting these cancers earlier, it is possible to not only save lives, as there is an 87% cure rate in cancers found by this type of surveillance, but also resources, as it is generally more cost-effective to treat an earlier disease than that which presents at a later stage.
	SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES
	Note: Testing and results should be summarized in this form. However, additional detail and reports may be submitted as supplemental information or provided as a web page URL. If a measure has not been tested, it is only potentially eligible for time-limited endorsement.
24	**Supplemental Testing Information:** attached ☐ **OR** Web page URL:
25 (2b)	**Reliability Testing** **Data/sample:** Data from commercial health plans were used to generate rates of colonoscopy follow-up, according to the algorithm specified above. Included health plans range from 500,000 members to 1.7

million members.

Analytic Method: Testing rates for Plans A and B were compared for stability over the course of two years.

Testing Results:

PLAN	2006 Rate	2007 Rate	2006 Denominator	2007 Denominator
Plan A	60.5%	59.8%	354	378
Plan B	68.3%	69.0%	277	274

26 (2c) **Validity Testing**

Data/sample: 2006 Data from five geographically diverse commercial health plans were used to generate rates of colonoscopy follow-up, according to the algorithm specified above. The size of the included health plans range from 180,000 members, to 2.4 million members.

Analytic Method:
PART 1: The algorithm for colonoscopy follow-up was run on 2006 data from all five plans. Denominator size and rate were calculated for each plan.
PART 2: Rates generated using this algorithm were compared to rates of colonoscopy follow-up found in the literature.

Testing Results:
PART 1:

PLAN	RATE	DENOMINATOR
Plan A	53.5%	406
Plan B	57.6%	278
Plan C	68.2%	277
Plan D	59.8%	378
Plan E	58.6%	418

Average Rate: 59.5% Standard Deviation: 5.4%
Average Denominator: 351

PART 2:

One follow-up study followed 62,882 medicaid benificiaries after diagnosis and resection of colorectal cancer. Colonoscopy was performed within within 18 months in 53.8% of patients, [1] a rate which is consistent with our findings.

Cooper, et al., Temporal trends in colorectal procedure use after colorectal cancer resection. Gastrointest Endosc, 2006. 64(6): p. 933-40. Other reported rates of testing are based on earlier guideline reccomendations for follow-up care which observed follow-up over a 3-year period.

27 (2d) **Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.*

Summary of Evidence supporting exclusion(s):
Members with a diagnosis of colorectal cancer and had a prior resection any time prior to the index date:

The intent of this measure is to identify newly diagnosed members with colorectal cancer in order to evaluate surveillance 15 months from the date of resection, therefore, members with previous diagnoses were excluded.

Members who were in hospice care 0 to 15 months after the index date:

Members who are in hospice care may forego treatment because they are terminally ill and care has been shifted to a palliative approach. Therefore, it is not fair to hold physicians who see these patients accountable. The inclusion of these patients would decrease the numerator, given that they would be less

	likely to undergo colonoscopy following resection. **Citations for Evidence:** N/A **Data/sample:** N/A **Analytic Method:** N/A **Testing Results:** N/A
28 (2e)	**Risk Adjustment Testing** *Summarize the testing used to determine the need (or no need) for risk adjustment and the statistical performance of the risk adjustment method.* **Data/sample:** N/A **Analytic Method:** N/A **Testing Results:** N/A ►**If outcome or resource use measure not risk adjusted, provide rationale:**
29 (2g)	**Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*) **Data/sample:** N/A **Analytic Method:** N/A **Results:** N/A
30 (2f)	**Provide Measure Results from Testing or Current Use** Results from testing **Data/sample:** See boxes 25 and 26 **Methods to identify statistically significant and practically/meaningfully differences in performance:** **Results:**
31 (2h)	**Identification of Disparities** ►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:** N/A ►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale:
	USABILITY
32 (3)	*Current Use Testing completed If in use, how widely used Health plan or sytem ► If "other," please describe:* ☐ *Used in a public reporting initiative, name of initiative:* *Sample report attached* ☐ *OR Web page URL:*
33 (3a)	**Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **Data/sample:** Data are reported as rates and denominator size. It was felt that no interpretability testing was needed. Based upon numerous interactions with health plans, performance based on denominator and rate are easily interpreted, as long as the populations captured in numerator, denominator and denominator exclusion are made explicit. **Methods:** N/A

	Results: N/A
34 (3b, 3c)	**Relation to other NQF-endorsed™ measures** ►Is this measure similar or related to measure(s) already endorsed by NQF (on the same topic or the same target population)? *Measures can be found at www.qualityforum.org under Core Documents.* *Check all that apply* ☐ Have not looked at other NQF measures ☐ Other measure(s) on same topic ☐ Other measure(s) for same target population ☒ No similar or related measures **Name of similar or related NQF-endorsed™ measure(s):** **Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one) ►If not fully harmonized, provide rationale: **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:**
	FEASIBILITY
35 (4a)	*How are the required data elements generated? Check all that apply* ☐ *Data elements are generated concurrent with and as a byproduct of care processes during care delivery (e.g., blood pressure or other assessment recorded by personnel conducting the assessment)* ☐ *Data elements are generated from a patient survey (e.g., CAHPS)* ☒ *Data elements are generated through coding performed by someone other than the person who obtained the original information (e.g., DRG or ICD-9 coding on claims)* ☐ *Other, Please describe:*
36 (4b)	*Electronic Sources All data elements* ►*If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:* ►*Specify the data elements for the electronic health record: ICD-9 diagnosis codes, ICD-9 Proc Codes, CPT-4 codes, HCPCS codes, UB revenue codes, NDC code, DRG codes*
37 (4c)	*Do the specified exclusions require additional data sources beyond what is required for the other specifications? No* ►*If yes, provide justification:*
38 (4d)	*Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure: This is an administrative claims-based quality indicator with certain potential biases, including coding variation between providers and missing data. Nevertheless, administrative claims data are widely available and have been used to effectively examine and document patterns of health care utilization, detect opportunities to improve quality of care, estimate incidence of disease, and even assess outcomes of pharmaceutical, radiological, and surgical procedures.* *Describe how could these potential problems be audited: HBI has developed an online tool (currently in use by several health plans), which allows physicians the opportunity to supplement their quality scores through self-report via a secured web site. Via this website, physicians are able to identify specific patients with whom they had an office visit during the measurement period and who reportedly did not have the indicated quality care. Physicians can then review their charts to verify whether in fact the quality care was performed. The physician can then manually enter corrections to the patient record via the website, indicating that the quality care was done. This data is subject to clinical review prior to acceptance. The hybrid quality score (via administrative claims and self report) can be updated on a quarterly basis.* *Did you audit for these potential problems during testing? No If yes, provide results:*
39	*Testing feasibility Describe what have you learned/modified as a result of testing and/or operational*

(4e)	*use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:* *Administrative claims data are automatically collected by commercial health plans.*
	CONTACT INFORMATION
40	*Web Page URL for Measure Information* *Describe where users (implementers) should go for more details on specifications of measures, or assistance in implementing the measure.* *Web page URL: N/A*
41	**Measure Intellectual Property Agreement Owner Point of Contact** **First Name:** Zak **MI:** **Last Name:** Ramadan-Jradi **Credentials (MD, MPH, etc.):** MD, MPH **Organization:** Health Benchmarks® **Street Address:** 21650 Oxnard St., Suite 550 **City:** Woodland Hills **State:** CA **ZIP:** 91367-7806 **Email:** zramadan@us.imshealth.com **Telephone:** 818-676-2820 ext:
42	**Measure Submission Point of Contact** **If different than IP Owner Contact** **First Name:** Karen **MI:** **Last Name:** Hsu **Credentials (MD, MPH, etc.):** MPH, MBA **Organization:** Health Benchmarks® **Street Address:** 21650 Oxnard St., Suite 550 **City:** Woodland Hills **State:** CA **ZIP:** 91367-7806 **Email:** khsu@us.imshealth.com **Telephone:** 541-550-7983 ext:
43	**Measure Developer Point of Contact** **If different than IP Owner Contact** **First Name:** Judy **MI:** Y **Last Name:** Chen **Credentials (MD, MPH, etc.):** MD, MSHS **Organization:** Health Benchmarks® **Street Address:** 21650 Oxnard St., Suite 550 **City:** Woodland Hills **State:** CA **ZIP:** 91367-7806 **Email:** judy.chen@us.imshealth.com **Telephone:** 818-676-2883 ext:
44	**Measure Steward Point of Contact** **If different than IP Owner Contact** *Identifies the organization that will take responsibility for updating the measure and assuring it is consistent with the scientific evidence and current coding schema; the steward of the measure may be different than the developer.* **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:** **Email:** **Telephone:** ext
	ADDITIONAL INFORMATION
45	**Workgroup/Expert Panel involved in measure development** No workgroup or panel used ►If workgroup used, describe the members' role in measure development: ►Provide a list of workgroup/panel members' names and organizations:
46	*Measure Developer/Steward Updates and Ongoing Maintenance* *Year the measure was first released: 2008* *Month and Year of most recent revision: November, 2008* *What is the frequency for review/update of this measure? Annually* *When is the next scheduled review/update for this measure? September, 2009*
47	**Copyright statement/disclaimers:** © 2008 Health Benchmarks® Confidential and Proprietary All Rights Reserved
48	**Additional Information:** N/A
49	**I have checked that the submission is complete and any blank fields indicate that no information is provided.** ☒
50	**Date of Submission** (*MM/DD/YY*)**:** 11/21/08

PATIENT & FAMILY ENGAGEMENT

PRIORITY STATEMENT: Engage Patients and Their Families in Managing Their Health and Making Decisions About Their Care

1.1. All providers will routinely solicit and publicly report on their patients' perspectives of care

1.2. All providers will work collaboratively with their patients to assist them in making informed decisions about treatment options consistent with their values and preferences

POPULATION HEALTH

PRIORITY STATEMENT: IMPROVE THE HEALTH OF THE U.S. POPULATION

2.1. The population will be up to date on all high-priority age- and gender-appropriate evidence-based clinical preventive services

2.2. The population will receive recommended evidence-based interventions to improve targeted healthy lifestyle behaviors

2.3. All communities will demonstrate a 10% improvement in their community index of health

2.4. Americans will have all recommended high priority healthy lifestyle behaviors under control

SAFETY

PRIORITY STATEMENT: IMPROVE THE SAFETY OF THE U.S. HEALTH CARE SYSTEM

3.1. All providers will drive all preventable healthcare-associated infections (HAI) to zero

3.2. All providers will drive the incidence of preventable NQF Serious Reportable Events (SRE) to zero

3.3. All hospitals will reduce preventable and premature mortality rates to best-in-class

3.4. All hospitals and their community partners will reduce 30-day mortality rates following hospitalization for select conditions to best-in-class

PALLIATIVE CARE

PRIORITY STATEMENT: GUARANTEE APPROPRIATE AND COMPASSIONATE CARE FOR PATIENTS WITH LIFE-LIMITING ILLNESSES

4.1. All providers will identify, document, and effectively treat physical symptoms (e.g. pain, shortness of breath, constipation, others) at levels acceptable to patients with a life-limiting illness

4.2. All providers will effectively address the psychosocial and spiritual needs of patients with life-limiting illnesses and their families according to their preferences

4.3. All eligible patients will receive high quality palliative care and hospice services

CARE COORDINATION

PRIORITY STATEMENT: ENSURE PATIENTS RECEIVE WELL-COORDINATED CARE ACROSS ALL PROVIDERS, SETTINGS, AND LEVELS OF CARE

5.1. All providers will accurately and completely reconcile medications across the continuum of care (i.e. admission, transfer within and between care providers, discharge, and outpatient appointments) and ensure communication with the next provider of services

5.2. All inpatient and outpatient providers will assess the patient's perspective of the coordination of their care using a validated care coordination survey tool

5.3. All providers will reduce 30-day all-cause readmission rates resulting from poorly coordinated care to best-in-class

5.4. All providers will reduce preventable emergency department (i.e. those that could be avoided with timely access to primary care) visits resulting from poorly coordinated care by 50%

PATIENT-FOCUSED CARE

PRIORITY STATEMENT: GUARANTEE HIGH VALUE CARE ACROSS ACUTE AND CHRONIC EPISODES

6.1. All patients will receive high-value care over the course of their acute or chronic illness

OVERUSE

PRIORITY STATEMENT: ELIMINATE WASTE WHILE ENSURING THE DELIVERY OF APPROPRIATE CARE

7.1. Reduce wasteful and inappropriate care for the top ten targeted areas by 50%

THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0
August 2008

The measure information you submit will be shared with NQF's Steering Committees and Technical Advisory Panels to evaluate measures against the NQF criteria of importance to measure and report, scientific acceptability of measure properties, usability, and feasibility. Four conditions (as indicated below) must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards. Not all acceptable measures will be strong—or equally strong—among each set of criteria. The assessment of each criterion is a matter of degree; however, all measures must be judged to have met the first criterion, importance to measure and report, in order to be evaluated against the remaining criteria. References to the specific measure evaluation criteria are provided in parentheses following the item numbers. Please refer to the *Measure Evaluation Criteria* for more information at *www.qualityforum.org* under Core Documents. Additional guidance is being developed and when available will be posted on the NQF website.

Use the tab or arrow (↓→) keys to move the cursor to the next field (or back ←↑). There are three types of response fields:

- drop-down menus - select one response;
- check boxes – check as many as apply; and
- text fields – you can copy and paste text into these fields or enter text; these fields are not limited in size, but in most cases, we ask that you summarize the requested information.

Please note that URL hyperlinks do not work in the form; you will need to type them into your web browser.

Be sure to answer all questions. Fields that are left blank will be interpreted as no or none. Information must be provided in this form. Attachments are not allowed except when specifically requested or to provide additional detail or source documents for information that is summarized in this form. If you have important information that is not addressed by the questions, they can be entered into item #48 near the end of the form.

For questions about this form, please contact the NQF Project Director listed in the corresponding call for measures.

	CONDITIONS FOR CONSIDERATION BY NQF
	Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards.
A (A)	*Public domain or Intellectual Property Agreement signed: IP Agreement signed and submitted (If no, do not submit)* *Template for the Intellectual Property Agreement is available at www.qualityforum.org under Core Documents.*
B (B)	*Measure steward/maintenance: Is there an identified responsible entity and process to maintain and update the measure on a schedule commensurate with clinical innovation, but at least every 3 years?* *Yes, information provided in contact section (If no, do not submit)*
C (C)	*Intended use: Does the intended use of the measure include BOTH public reporting AND quality improvement? Yes (If no, do not submit)*
D (D)	*Fully developed and tested: Is the measure fully developed AND tested? Yes, fully developed and tested (If not tested and no plans for testing within 24 months, do not submit)*

THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0

August 2008

	(for NQF staff use) NQF Review #: NQF Project:
	MEASURE SPECIFICATIONS & DESCRIPTIVE INFORMATION
1	*Information current as of (date- MM/DD/YY): 7/9/09*
2	*Title of Measure: Annual Cervical Cancer Screening for High-Risk Patients*
3	**Brief description of measure [1]:** This measure identifies women greater than age 12 to age 65 diagnosed with cervical dysplasia (CIN 2), cervical carcinoma-in-situ, or HIV/AIDS prior to the measurement year, and who still have a cervix, who had a cervical CA screen during the measurement year.
4 (2a)	**Numerator Statement:** Patients in the denominator who had a cervical CA screen during the measurement year **Time Window:** **Numerator Details** (Definitions, codes with description): >=1 procedure claim for a cervical cancer screen during the measurement year **cervical cancer screen (Procedure)** ========== Type Code Description ------- ------- ---------- ICD9P 9146 CELL BLK&PAP SMER SPEC FE GNT TRACT CPT4 88141 CYTOPATH, C/V, INTERPRET CPT4 88141 CYTOPATH CERV/VAG RQR INTEPR PHYS CPT4 88142 CYTPTH CERV/VAG; THIN PREP; MNL SCR CPT4 88143 CYTOPATH CERV/VAG; W/MNL SCR-RESCR CPT4 88147 CYTOPATH CERV/VAG; AUTO SCR-SUPRVS CPT4 88148 CYTOPATH CERV/VAG; SCR-RESCR-SUPRVS CPT4 88150 CYTOPATH CERV/VAG; MNL SCR PHYS SUP CPT4 88152 CYTPTH SLDE CERV/VAG; MNL-CMPUTR CPT4 88153 CYTOPATH CERV/VAG; MNL SCR-RESCR CPT4 88154 CYTOPATH CERV/VAG; SCR-RESCR-CELL CPT4 88155 CYTPTH SLIDES CERV/VAG DEF HORMONAL CPT4 88164 CYTOPATH CERV/VAG BETHSEDA;MNL PHYS CPT4 88165 CYTOPATH SLIDES-CERV; MNL SCR&RESCR CPT4 88166 CYTOPATH SLIDES-CERV; MNL-COMPU SCR CPT4 88167 CYTOPATH SLIDES-CERV/VAG; SCR CELL CPT4 88174 CYTOPATH CERV/VAG THIN LAY PREP;SCR CPT4 88175 CYTOPATH C/V AUTO FLUID REDO CPT4 88175 CYTOPATH CERV/VAG THIN PREP; RESCR HCPCS G0101 CERV/VAG CANCR SCR;PELV&CLN BRST EX HCPCS G0123 SCR CERV/VAG THIN LAY W/PHYS SUP HCPCS G0124 SCR CERV/VAG THIN LAY PHYS INTERP HCPCS G0141 SCR CERV/VAG MNL RSCR PHYS INTERP HCPCS G0143 SCR CERV/VAG MNL SCR/RSCR UND PHYS HCPCS G0144 SCR CERV/VAG SCR AUTO UND PHYS HCPCS G0145 SCR CERV/VAG AUTO&MNL RSCR PHYS HCPCS G0147 SCR SMEARS CERV/VAG AUTO UND PHYS HCPCS G0148 SCR SMEARS CERV/VAG MNL RESCR HCPCS P3000 SCR PAP SMER UP TO 3 TECH W/MD SUPV HCPCS P3001 SCR PAP SMER UP TO 3 RQR INTEPR MD HCPCS Q0091 SCR PAP SMER; OBTAIN PREP&CONVY-LAB HSREV 0923 Other Diagnostic Services

[1] Example of measure description: Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year.

Cervical Cancer Screen (Diagnosis)

Type	Code	Description
ICD9	V7232	ENCOUNTR PAP CONFRM NL SMER FLW ABN
ICD9	V762	SCREENING MALIGNANT NEOPLASM CERVIX

5

(2a)

Denominator Statement: Women who are 12-65 years of age who have a diagnosis of cervical dysplasia (CIN 2), cervical carcinoma-in-situ, or HIV/AIDS diagnosed prior to the measurement year, and who still have a cervix (excludes women with a hysterectomy and no residual cervix)

Time Window:

Denominator Details (Definitions, codes with description):

- Age >12 and <65 years old as of the end of the measurement year
- AND female
- AND at least 1 claim prior to the measurement year for 1 or more of the following diagnoses:
    - cervical dysplasia (CIN 2), or
    - cervical carcinoma in-situ (CIN 3), or
    - HIV/AIDS, or
    - DES exposure in Utero, or
    - Transplant, or
    - Transplant Status

- And eligible for service benefits for 2 years preceding the end of the measurement year

cervical CIS (CIN1)(Diagnosis)

Type	Code	Description
ICD9	2331	CARCINOMA IN SITU OF CERVIX UTERI

cervical dysplasia (CIN2) (Diagnosis)

Type	Code	Description
ICD9	62212	MODERATE DYSPLASIA OF CERVIX

HIV AIDS (Diagnosis)

Type	Code	Description
ICD9	042	HUMAN IMMUNODEFICIENCY VIRUS [HIV]
ICD9	07953	HIV TYPE 2 IN CCE & UNS SITE
ICD9	V08	ASYMPTOMATIC HIV INFECTION STATUS

DES Exposure in Utero (Diagnosis)

Type	Code	Description
ICD9	76076	DES EXPOSURE IN UTERO

Transplant (Procedure)

Type	Code	Description
CPT4	48554	TRANSPLANTATION PANCREATIC ALLOGFT
CPT4	48160	PANCREATECT W/TPLNT PANC/ISLET CELL
ICD9P	528	TRANSPLANT OF PANCREAS
ICD9P	5280	PANCREATIC TRANSPLANT NOS
ICD9P	5281	REIMPLANTATION OF PANCREATIC TISSUE
ICD9P	5282	HOMOTRANSPLANT OF PANCREAS
ICD9P	5283	HETEROTRANSPLANT OF PANCREAS
ICD9P	5284	AUTOTPLNT CELLS ISLETS LANGERHANS
ICD9P	5285	ALLOTPLNT CELLS ISLETS LANGERHANS

ICD9P	5286 TPLNT CELLS ISLETS LANGERHANS NOS
ICD9P	4108 ALLO HEMAT STEM CELL TRNSPLT W/PURG
ICD9P	4109 AUTOL BN MARROW TPLNT W/PURGING
ICD9P	410 BONE MARROW TRANSPLANT
ICD9P	3751 HEART TRANSPLANTATION
ICD9P	335 LUNG TRANSPLANT
ICD9P	5051 AUXILIARY LIVER TRANSPLANT
ICD9P	5059 OTHER TRANSPLANT OF LIVER
ICD9P	5569 OTHER KIDNEY TRANSPLANTATION
CPT4	00580 ANESTH, HEART/LUNG TRANSPLNT
CPT4	00796 ANESTH, FOR LIVER TRANSPLANT
CPT4	00868 ANESTH, KIDNEY TRANSPLANT
CPT4	32851 LUNG TRANSPLANT, SINGLE
CPT4	32852 LUNG TRANSPLANT WITH BYPASS
CPT4	32853 LUNG TRANSPLANT, DOUBLE
CPT4	47135 LIVER ALLOTRANSPL; ORTHOTOP-PRT/ALL
CPT4	47136 LIVER ALLOTRANSPL; HETEROTOPIC
CPT4	47140 DONR HEPATECT LIVE DONR; LT LAT SEG
CPT4	50360 RENAL ALLOTRANSPL;W/O DONR NEPHRECT
CPT4	50365 RENAL ALLOTRANSPL; W/RECIP NEPHRECT
ICD9P	505 LIVER TRANSPLANT
ICD9P	4102 ALLOGENEIC MARROW TRANSPL-PURGE
ICD9P	4103 ALLOGENEIC BONE MARROW TRANSPL
ICD9P	4104 AUTO HEMAT ST CELL TRNSPLT W/O PURG
ICD9P	4105 ALLO HEMAT ST CELL TRNSPLT W/O PURG
ICD9P	4106 CORD BLOOD STEM CELL TRANSPLANT
ICD9P	4107 AUTO HEMAT ST CELL TRNSPLT W PURG
CPT4	33945 TRANSPLANTATION OF HEART
CPT4	38240 BONE MARROW/STEM CELL TRANSPL; ALLO
CPT4	38241 BONE MARROW/STEM CELL TRANSPL; AUTO
CPT4	38242 BN MARROW/BLD STEM CELL TPLNT; ALLO
ICD9P	4100 BONE MARROW TRANSPLANT NOS
ICD9P	4101 AUTOL BN MARROW TPLNT W/O PURGING
CPT4	32854 LUNG TRANSPLANT WITH BYPASS
ICD9P	3350 LUNG TRANSPLANTATION NOS
ICD9P	3351 UNILATERAL LUNG TRANSPLANTATION
ICD9P	3352 BILATERAL LUNG TRANSPLANTATION
ICD9P	336 COMBINED HEART-LUNG TRANSPLANTATION
CPT4	33935 HEART-LUNG TRANSPL W/RECIPIENT

Transplant status (Diagnosis)

Type	Code	Description
ICD9	9968	COMPLICATIONS OF TRANSPLANTED ORGAN
ICD9	99680	COMPS TPLNT ORGAN UNSPEC SITE
ICD9	99681	COMPLICATIONS TRANSPLANTED KIDNEY
ICD9	99682	COMPLICATIONS OF TRANSPLANTED LIVER
ICD9	99683	COMPLICATIONS OF TRANSPLANTED HEART
ICD9	V4282	PERIPH STEM CELLS REPLCD TRANSPLANT
ICD9	V4283	PANCREAS REPLACED BY TRANSPLANT
ICD9	V4284	ORGN/TISS REPLCD TRANSPLANT INTEST
ICD9	V4289	OTH ORGAN/TISSUE REPLCD TRANSPLANT
ICD9	V429	UNSPEC ORGN/TISS REPLCD TRANSPLANT
ICD9	V420	KIDNEY REPLACED BY TRANSPLANT
ICD9	V421	HEART REPLACED BY TRANSPLANT
ICD9	V426	LUNG REPLACED BY TRANSPLANT
ICD9	V427	LIVER REPLACED BY TRANSPLANT
ICD9	V428	OTH SPEC ORGN/TISS REPLCD TPLNT
ICD9	V4281	BONE MARROW REPLACED BY TRANSPLANT
ICD9	99684	COMPLICATIONS OF TRANSPLANTED LUNG
ICD9	99685	COMPS BONE MARROW TRANSPLANT
ICD9	99686	COMPLICATIONS TRANSPLANTED PANCREAS
ICD9	99687	COMPS TRANSPLANTED ORGAN INTESTINE
ICD9	99689	COMPS OTH TRANSPLANTED ORGAN
ICD9	V42	ORGAN OR TISSUE REPLACED TRANSPLANT

	ICD9 1992 MALIG NEOPLSM ASSOC TRANSPLNT ORGAN
6 (2a, 2d)	**Denominator Exclusions:** No claims for cervical cancer screening exclusions, based on NCQA/HEDIS technical specifications: Women who had a hysterectomy with no residual cervix. **Denominator Exclusion Details** (Definitions, codes with description): **cervical CA screen exclusion hysterectomy (Procedure)** ========== Type Code Description ------ ------ ---------- ICD9P 684 TOTAL ABDOMINAL HYSTERECTOMY ICD9P 6841 LAPAROSCOPIC TOTAL ABDOMINAL HYST ICD9P 6849 OTHER & UNSPEC TOTAL ABDOMINAL HYST ICD9P 685 VAGINAL HYSTERECTOMY ICD9P 6851 LAPAROSCOPICALLY ASSISTED VAG HYST ICD9P 6859 OTHER VAGINAL HYSTERECTOMY ICD9P 686 RADICAL ABDOMINAL HYSTERECTOMY ICD9P 6861 LAPAROSCOPIC RADICAL ABDOMINAL HYST ICD9P 6869 OTH&UNSPEC RADICAL ABD HYSTERECTOMY ICD9P 687 RADICAL VAGINAL HYSTERECTOMY ICD9P 6871 LAPAROSCOPIC RADICAL VAG HYST ICD9P 6879 OTHER&UNSPECIFIED RADICAL VAG HYST ICD9P 688 PELVIC EVISCERATION CPT4 51925 CLOS VESICOUTERINE FIST; W/HYST CPT4 58150 TAH W/WO REMOVAL TUBE-OVARY CPT4 58152 TAH; W/COLPO-URETHROCYSTOPEXY CPT4 58200 TAH W/PART VAGINECT W/LYMPH NODE CPT4 58210 RAD ABD HYST W/BIL TOT PELV LYMPHDN CPT4 58240 PELV EXENTERAT W/TAH/CERVICECTOMY CPT4 58260 VAG HYST UTERUS 250 GRAMS OR LESS; CPT4 58260 VAGINAL HYSTERECTOMY CPT4 58262 VAG HYST INCLUDING T/O CPT4 58262 VAG HYST UTRUS 250 GMS/<; REMV T&/O CPT4 58263 VAG HYST W/T/O & VAG REPAIR CPT4 58263 VAG HYST UTRUS 250 GM/<;REP ENTERCL CPT4 58267 VAG HYST 250 GM/<;CLPO-URTHRCYSTPXY CPT4 58267 VAG HYST W/URINARY REPAIR CPT4 58270 VAG HYST UTRUS 250 GM/<;REP ENTROCL CPT4 58270 VAG HYST W/ENTEROCELE REPAIR CPT4 58275 VAG HYST W/TOTAL/PART VAGINECTOMY; CPT4 58280 VAG HYST W/VAGINECT; W/REP ENTEROCL CPT4 58285 VAGINAL HYSTERECTOMY RADICAL CPT4 58290 VAG HYST UTERUS > 250 GRAMS; CPT4 58291 VAG HYST UTRUS>250 GMS; REMV T&/O CPT4 58292 VAG HYST UTRUS>250 GM; T&/O ENTROCL CPT4 58293 VAG HYST UT>250 GM;CLPO-URTHRCYSTPX CPT4 58294 VAG HYST UTRUS >250 GM;REP ENTEROCL CPT4 58550 LAP SURG VAG HYST UTRUS 250 GMS/<; CPT4 58552 LAP VAG HYST UTRUS 250 GMS/<; T&/O LAP W/VAG HYST UTRUS > 250 GMS; CPT4 58553 CPT4 58554 LAP VAG HYST UTRUS>250 GM;REMV T&/O CPT4 58570 TLH, UTERUS 250 G OR LESS CPT4 58571 TLH W/T/O 250 G OR LESS CPT4 58572 TLH, UTERUS OVER 250 G CPT4 58573 TLH W/T/O UTERUS OVER 250 G CPT4 58951 RES OVAR/TUBL MALIG; W/TAH&LYMPHECT CPT4 58951 RESECT OVARIAN MALIGNANCY CPT4 58953 BIL S-O W/OMENTECT TAH&RADL DEBULK; CPT4 58954 BIL S-O OMENTECT TAH; PELV LYMPHECT CPT4 58956 BIL S-O W/TOT OMENTECT TAH MALIG CPT4 59135 SURG TX ECTOP PG; REQ TOT HYSTERECT

	Hysterectomy (Diagnosis) ========== Type Code Description ------- ------- ---------- ICD9 6185 PROLAPSE VAGINAL VAULT AFTER HYST ICD9 V6701 FOLLOW SURG F/U VAGINAL PAP SMEAR ICD9 V7647 SPECIAL SCR MALIG NEOPLSM VAGINA
7 (2a, 2h)	**Stratification** Do the measure specifications require the results to be stratified? No ► If "other" describe: **Identification of stratification variable(s):** **Stratification Details** (Definitions, codes with description):
8 (2a, 2e)	**Risk Adjustment** Does the measure require risk adjustment to account for differences in patient severity before the onset of care? No ► **If yes,** (select one) ► Is there a separate proprietary owner of the risk model? No **Identify Risk Adjustment Variables:** **Detailed risk model:** attached ☐ **OR** Web page URL:
9 (2a)	**Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☒ **OR** Web page URL: **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 ► If "Other", please describe:
10 (2a. 4a, 4b)	**Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** primary diagnosis**,** procedure codes **Data dictionary/code table** attached ☒ see numerator and denominator detail **OR** Web page URL: **Data Quality** (2a) *Check all that apply* ☐ Data are captured from an authoritative/accurate source (e.g., lab values from laboratory personnel) ☒ Data are coded using recognized data standards ☐ Method of capturing data electronically fits the workflow of the authoritative source ☐ Data are available in EHRs ☒ Data are auditable
11 (2a, 4b)	**Data Source and Data Collection Methods** *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply* ☐ Electronic Health/Medical Record ☐ Electronic Clinical Database, Name: ☐ Electronic Clinical Registry, Name: ☒ Electronic Claims ☒ Electronic Pharmacy data ☐ Electronic Lab data ☐ Electronic source – other, Describe: ☐ Paper Medical Record ☐ Standardized clinical instrument, Name: ☐ Standardized patient survey, Name: ☐ Standardized clinician survey, Name: ☐ Other, Describe: It is reasonable to allow physicians to submit definitive evidence that a particular service was provided to a patient. For example, a lab result from a testing facility would indicate that that lab test was performed. A notation in a patient chart that the test was ordered, in contrast, would not provide definitive evidence that the test was performed. Instrument/survey attached ☐ **OR** Web page URL:
12 (2a)	**Sampling** *If measure is based on a sample, provide instructions and guidance on sample size.* **Minimum sample size:** 10 **Instructions: :** We have developed a hierarchical logistic regression model with expert biostatisticians at

	the Johns Hopkins School of Public Health that enables one to produce a probability distribution around a point estimate of the "quality score" for a given physician. This model has shown that there is no minimum sample size that is required to produce a quality score which has a comparatively "tight" probability distribution. Rather, the number of required observations depends on how a given physician performs on particular measures compared to how all other MDs perform on those measures. We recommend that a minimum of 10 observations be required, however, because of the normality assumptions that underlies the model and for public "face validity". Alternatively, to satisfy current NCQA standards, a minimum of 30 observations could be required.
13 (2a)	**Type of Measure:** Process ► If "Other", please describe: ► If part of a composite or paired with another measure, please identify composite or paired measure
14 (2a)	**Unit of Measurement/Analysis** (*Who or what is being measured*) *Check all that apply.* ☐ Can be measured at all levels ☒ Individual clinician (e.g., physician, nurse) ☒ Group of clinicians (e.g., facility department/unit, group practice) ☐ Facility (e.g., hospital, nursing home) ☒ Integrated delivery system ☒ Health plan ☒ Community/Population ☐ Other (*Please describe*):
15 (2a)	**Applicable Care Settings** *Check all that apply* ☐ Can be used in all healthcare settings ☒ Ambulatory Care (office/clinic) ☐ Behavioral Healthcare ☒ Community Healthcare ☐ Dialysis Facility ☐ Emergency Department ☐ EMS emergency medical services ☒ Health Plan ☐ Home Health ☐ Hospice ☐ Hospital ☐ Long term acute care hospital ☐ Nursing home/ Skilled Nursing Facility (SNF) ☐ Prescription Drug Plan ☐ Rehabilitation Facility ☐ Substance Use Treatment Program/Center ☐ Other (*Please describe*):
	IMPORTANCE TO MEASURE AND REPORT
	Note: This is a threshold criterion. If a measure is not judged to be sufficiently important to measure and report, it will not be evaluated against the remaining criteria.
16 (1a)	**Addresses a Specific National Priority Partners Goal** *Enter the numbers of the specific goals related to this measure (see list of goals on last page)*: 2.1, 2.2, 2.3, 2.4, 3.4 5.3, 5.4, 6.1
17 (1a)	**If not related to NPP goal, identify high impact aspect of healthcare** (select one) **Summary of Evidence:** **Citations[2] for Evidence:**
18 (1b)	**Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.* **Summary of Evidence:** numerator denominator proportion --- 2835 3611 78.5% **Citations for Evidence:** RHI testing experience
19 (1b)	**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.* **Summary of Evidence:** **Citations for evidence:**

[2] Citations can include, but are not limited to journal articles, reports, web pages (URLs).

20 (1c)

If measuring an Outcome Describe relevance to the national health goal/priority, condition, population, and/or care being addressed:

If not measuring an outcome, provide evidence supporting this measure topic and grade the strength of the evidence

Summarize the evidence (including citations to source) supporting the focus of the measure as follows:

- Intermediate outcome – evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit.
- Process – evidence that the measured clinical or administrative process leads to improved health/avoidance of harm and
  if the measure focus is on one step in a multi-step care process, it measures the step that has the greatest effect on improving the specified desired outcome(s).
- Structure – evidence that the measured structure supports the consistent delivery of effective processes or access that lead to improved health/avoidance of harm or cost/benefit.
- Patient experience – evidence that an association exists between the measure of patient experience of health care and the outcomes, values and preferences of individuals/ the public.
- Access – evidence that an association exists between access to a health service and the outcomes of, or experience with, care.
- Efficiency– demonstration of an association between the measured resource use and level of performance with respect to one or more of the other five IOM aims of quality.

Type of Evidence *Check all that apply*

☒ Evidence-based guideline
☐ Meta-analysis
☐ Systematic synthesis of research
☐ Quantitative research studies
☐ Qualitative research studies
☐ Other (*Please describe*):

Overall Grade for Strength of the Evidence[3] (*Use the USPSTF system, or if different, also describe how it relates to the USPSTF system)***:**

Summary of Evidence (*provide guideline information below*)**:**

Citations for Evidence: See question #21 below

21 (1c)

Clinical Practice Guideline *Cite the guideline reference; quote the specific guideline recommendation related to the measure and the guideline author's assessment of the strength of the evidence; and summarize the rationale for using this guideline over others.*

Guideline Citation: ACOG Committee on Practice Bulletins. ACOG Practice Bulletin: clinical management guidelines for obstetrician-gynecologists. Number 45, August 2003. Cervical cytology screening (replaces committee opinion 152, March 1995). Obstet Gynecol. 2003 Aug;102(2):417-27.

Specific guideline recommendation:

Women infected with human immunodeficiency virus (HIV) should have cervical cytology screening twice in the first year after diagnosis and annually thereafter. Women treated in the past for CIN 2 or CIN3 or cancer remain at risk for persistent or recurrent disease and should continue to be screened annually.

Guideline author's rating of strength of evidence (*If different from USPSTF, also describe it and how it relates to USPSTF)***:** B

Rationale for using this guideline over others:

[3]The strength of the body of evidence for the specific measure focus should be systematically assessed and rated, e.g., USPSTF grading system www.ahrq.gov/clinic/uspstmeth.htm: A - The USPSTF recommends the service. There is high certainty that the net benefit is substantial. B - The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. C - The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. Offer or provide this service only if other considerations support the offering or providing the service in an individual patient. D - The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. I - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

22 (1c)	**Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.* **Summary** The USPSTF recommendations for cervical cancer screening does not support increased frequency of cervical cancer screening for women, including those with high-risk factors, noting, "The USPSTF found no direct evidence that annual screening achieves better outcomes than screening every 3 years. Modeling studies suggest little added benefit of more frequent screening for most women… the American College of Obstetricians and Gynecologists (ACOG) identifies additional risk factors that might justify annual screening, including a history of cervical neoplasia, infection with HPV or other sexually transmitted diseases (STDs), or high-risk sexual behavior, but data are limited to determine the benefits of these strategies." In contrast, the ACOG's guidelines state, "Certain risk factors have been associated with CIN in observational studies… Women infected with HIV should have cervical cytology screening twice in the first year after diagnosis and annually thereafter. Women treated in the past for CIN2 or CIN3 or cancer remain at risk for persistent or recurrent disease and should continue to be screened annually." **Citations: :** Guide to Clinical Preventive Services, 2008. Recommendations of the U.S. Preventive Services Task Force. AHRQ Publication No. 08-05122, September 2008. Agency for Healthcare Research and Quality, Rockville, MD. ACOG Committee on Practice Bulletins. ACOG Practice Bulletin: clinical management guidelines for obstetrician-gynecologists. Number 45, August 2003. Cervical cytology screening (replaces committee opinion 152, March 1995). Obstet Gynecol. 2003 Aug;102(2):417-27.
23 (1)	**Briefly describe how this measure (as specified) will facilitate significant gains in healthcare quality related to the specific priority goals and quality problems identified above: :** By identifying specific patients in whom care is not consistent with the clinical practice guideline underlying the measure, the measure will facilitate improvement in the care for those patients by highlighting the patient-specific QI opportunity for the patient's physician(s). In addition, the feedback physicians will receive on their overall performance on this measure will help focus their attention on the underlying care issue and improve their performance on that issue across all of their patients. If performance measurement is combined with some sort of financial incentive, such as in a pay for performance program, the QI impact may be increased.
	SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES
	Note: Testing and results should be summarized in this form. However, additional detail and reports may be submitted as supplemental information or provided as a web page URL. If a measure has not been tested, it is only potentially eligible for time-limited endorsement.
24	**Supplemental Testing Information:** attached ☐ **OR** Web page URL:
25 (2b)	**Reliability Testing** **Data/sample:** We have tested this measure on several patient populations, including, in total, more than 30 million people enrolled in 18 different health plans. In addition, we have used analogous computer algorithms to identify patient-specific QI opportunities in more than 5 million health plan members and have sent messages regarding those opportunities to either the member or the member's physician or both. **Analytic Method:** The validity of a physician quality score describes how accurately it estimates the true value. Reliability is the stability or consistency of an estimator from one data set to the next. Both are important in assessing the performance of the quality score. We have used the following measure as an indication of the reliability of each of our measures: 1 minus [(the variance of the posterior distribution of the physician quality score) divided by (the variance of the true physician quality score)], which is the reduction in the variance of a doctor's performance score (posterior distribution) obtained by using his or her performance data, expressed as a fraction of the total variance before any data is collected. **Testing Results:** The reliability of a physician quality score depends on the number of observations available for a given physician, how the physician performs relative to all other physician, and the overall variance in physician quality scores. As a result, reliability varies with the population of MDs in whom the measure is used. In our experience, reliability is in the range of 0.5 to >0.7.

26 (2c)	**Validity Testing** **Data/sample:** We have tested this measure on several patient populations, including, in total, more than 30 million people enrolled in 18 different health plans. In addition, we have used analogous computer algorithms to identify patient-specific QI opportunities in more than 5 million health plan members and have sent messages regarding those opportunities to either the member or the member's physician or both. **Analytic Method:** We have employed several approaches to ensure the validity of this measure: 1) we've ensured that the technical specifications for this measure are valid reflections of the underlying clinical practice guideline; 2) we have obtained feedback on the validity of the measure from several physician panels that were assembled by either Care Focused Purchasing or the Massachusetts Group Insurance Commission Clinical Performance Improvement Initiative, or both, and 3) we have systematically collected feedback from physicians and health plan members to whom we have sent messages regarding this measure. **Testing Results:** This measure is considered to be valid by the physician panels that have reviewed it. (More information regarding the panels is provided elsewhere in this document.) In addition, the measure has been considered to be valid by the medical directors of 17 different health plans. In addition, the fact that thousands of physicians have received results based on this measure without indicating that they don't believe the measure is valid attests to its validity.
27 (2d)	**Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.* **Summary of Evidence supporting exclusion(s):** RHI's measure "Annual Cervical Cancer Screening for High-Risk Patients" excludes women who have had a hysterectomy with no residual cervix in the past. This exclusion is modeled after the one employed by NCQA/HEDIS for their "Cervical Cancer Screening" measure. Women without a cervix are no longer at risk for developing cervical cancer. **Citations for Evidence:** National Committee for Quality Assurance. HEDIS 2009. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol 2, 2008. **Data/sample:** **Analytic Method:** **Testing Results:**
28 (2e)	**Risk Adjustment Testing** *Summarize the testing used to determine the need (or no need) for risk adjustment and the statistical performance of the risk adjustment method.* **Data/sample:** **Analytic Method:** **Testing Results:** ►**If outcome or resource use measure not risk adjusted, provide rationale:** There is no need to risk adjust results from this measure. To the extent that the measure applies only to patients in a particular risk category, that has been taken into account in the specifications for the denominator or exclusions for this measure
29 (2g)	**Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*) **Data/sample:** **Analytic Method:** **Results:**
30	**Provide Measure Results from Testing or Current Use** (select one)

(2f)

Data/sample: RHI testing experience

Methods to identify statistically significant and practically/meaningfully differences in performance: We have developed a hierarchical logistic regression model with expert biostatisticians at the Johns Hopkins School of Public Health that enables one to produce a probability distribution around a point estimate of the "quality score" for a given physician. This model has shown that there is no minimum sample size that is required to produce a quality score which has a comparatively "tight" probability distribution. Rather, the number of required observations depends on how a given physician performs on particular measures compared to how all other MDs perform on those measures. We recommend that a minimum of 10 observations be required, however, because of the normality assumption that underlies the model and for public "face validity". Alternatively, to satisfy current NCQA standards, a minimum of 30 observations could be required. We have employed this statistical approach in the MD quality profiling we performed on the experience of more than 2 million members of 6 health plans participating in the Massachusetts Group Insurance Commission Clinical Performance Improvement Initiative in 2008.

Results:

numerator	denominator	proportion
2835	3611	78.5%

31 (2h)

Identification of Disparities

►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:**

►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale:

USABILITY

32 (3)

Current Use In use *If in use, how widely used Nationally* ► *If "other," please describe:*

☒ *Used in a public reporting initiative, name of initiative: Group Insurance Commission of Massachusetts, Clinical Performance Improvement Initiative; Care Focused Purchasing*
Sample report attached ☐ *OR Web page URL:*

33 (3a)

Testing of Interpretability (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*)

Data/sample: We have tested this measure on several patient populations, including, in total, more than 30 million people enrolled in 18 different health plans.

Methods: The results have been provided to the medical directors of the 18 health plans, all of whom have indicated that they understand the particular aspect of care that the measure addresses and how to interpret the result for a physician. In addition, results have been presented to HR directors from >60 national employers.

Results: Both the health plan medical directors and the HR personnel from the employers have indicated that they understand the particular aspect of care that the measure addresses and how to interpret the result for a physician. We do not have data on the extent to which individual physicians understand the measure result, but we presume that, since health plan medical directors and non-medical personnel from employers understand the result, that physicians and lay people will also so long that adequate explanation is provided.

34 (3b, 3c)

Relation to other NQF-endorsed™ measures

►Is this measure similar or related to measure(s) already endorsed by NQF (on the same topic or the same target population)? *Measures can be found at www.qualityforum.org under Core Documents.*
Check all that apply

	☐ Have not looked at other NQF measures ☐ Other measure(s) on same topic ☐ Other measure(s) for same target population ☒ No similar or related measures **Name of similar or related NQF-endorsed™ measure(s):** **Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one) ►If not fully harmonized, provide rationale: **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** This measure can be used exclusively with enriched administrative data
	FEASIBILITY
35 (4a)	*How are the required data elements generated? Check all that apply* ☐ *Data elements are generated concurrent with and as a byproduct of care processes during care delivery (e.g., blood pressure or other assessment recorded by personnel conducting the assessment)* ☐ *Data elements are generated from a patient survey (e.g., CAHPS)* ☒ *Data elements are generated through coding performed by someone other than the person who obtained the original information (e.g., DRG or ICD-9 coding on claims)* ☐ *Other, Please describe:*
36 (4b)	*Electronic Sources All data elements* ►*If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:* ►*Specify the data elements for the electronic health record:*
37 (4c)	*Do the specified exclusions require additional data sources beyond what is required for the other specifications? No* ►*If yes, provide justification:*
38 (4d)	*Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure: As with any type of clinical performance measure, and with any source of data used to operationalize the measure, there will be some instances in which the data used to compute the measure are incomplete or inaccurate. We try to minimize the impact of such errors or omissions through the way we have constructed the technical specifications for the measure. There is no data source for performance measurement that is completely accurate. Two studies have shown that physician performance tends to be better when assessed using claims data compared to via chart abstraction.* *Describe how could these potential problems be audited: Potential data errors of omission or commission could be audited through chart abstraction, or feedback from physicians and patients. However, as mentioned above, each of these alternative sources of information also are susceptible to error and thus are not true gold standards.* *Did you audit for these potential problems during testing? Yes If yes, provide results: Through feedback from physicians whose performance has been evaluated*
39 (4e)	*Testing feasibility Describe what have you learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:*
	CONTACT INFORMATION
40	*Web Page URL for Measure Information Describe where users (implementers) should go for more details on specifications of measures, or assistance in implementing the measure.* *Web page URL: www.resolutionhealth.com*
41	**Measure Intellectual Property Agreement Owner Point of Contact**

	First Name: Alan **MI:** **Last Name:** Lefkowitz **Credentials (MD, MPH, etc.):** **Organization:** Resolution Health **Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044 **Email:** alefkowitz@resolutionhealth.com **Telephone:** 240-295-5834 ext:
42	**Measure Submission Point of Contact** **If different than IP Owner Contact** **First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP **Organization:** Resolution Health **Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044 **Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext:
43	**Measure Developer Point of Contact** **If different than IP Owner Contact** **First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP **Organization:** Resolution Health **Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044 **Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext:
44	**Measure Steward Point of Contact** **If different than IP Owner Contact** *Identifies the organization that will take responsibility for updating the measure and assuring it is consistent with the scientific evidence and current coding schema; the steward of the measure may be different than the developer.* **First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP **Organization:** Resolution Health **Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044 **Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext:
	ADDITIONAL INFORMATION
45	**Workgroup/Expert Panel involved in measure development** Workgroup/panel used ►If workgroup used, describe the members' role in measure development: Over the past several years, two formal workgroups -- one organized by the Care Focused Purchasing initiative and one organized by the Massachusetts Group Insurance Commission Clinical Performance Improvement Initiative -- and several ad hoc experts have provided useful input to our measure development and refinement processes. In each case, we have provided the Work Group Members with details regarding each of our performance measures and members of the work group (not always all members) have provided feedback on the validity of the clinical practice guideline underlying the measure and suggestions regarding potential ways to improve the technical specifications for the measure. In some instances, we have eliminated measures based on feedback from the work groups. In other instances, work group members have proposed new measures. We try to get feedback from work group members and selected clinical experts on an annual basis. ►Provide a list of workgroup/panel members' names and organizations: **Care Focused Purchasing Clinical Advisory Panel** Bobbie Berg -BCBS -IL Dow Briggs - BCBS- AL Joe Calderella - Cigna Carl Cameron - Preferred Care Steven Goldberg – Humana Tom James – Humana Don Liss – Aetna Catherine MacLean – WellPoint Zak Ramadan–Jradi – Regence Fred Volkman – Avidyn Health Constance Hwang – Resolution Health Darren Schulte - Resolution Health Earl Steinberg – Resolution Health **Massachusetts Group Insurance Commission Physician Advisory Panel** Jim Glauber – Neighborhood Health Plan Lyn Laurenco - Neighborhood Health Plan Anton Dodek - Tufts Barbara Chase - Fallon

	Jonathan Scott Coblyn – Brigham and Women's Hospital Tom Ebert - Health New England Elaine Wilson - Harvard Pilgrim Health Care Jennifer St. Thomas – Tufts Jennifer Lavigne – Fallon Michael O'Shea - Baycare Health Neil Minkoff - Harvard Pilgrim Health Care Paul Mendis- Neighborhood Health Plan Bob Jordan - Neighborhood Health Plan Bob Sorrenti – Unicare Constance Williams – Unicare Laura Syron - Neighborhood Health Plan Susan Tiffany – Unicare Constance Hwang – Resolution Health Darren Schulte - Resolution Health Earl Steinberg – Resolution Health David Gregg – Mercer Russ Robinson - Mercer
46	*Measure Developer/Steward Updates and Ongoing Maintenance* *Year the measure was first released: 2004* *Month and Year of most recent revision: October 2008* *What is the frequency for review/update of this measure? Annual Review* *When is the next scheduled review/update for this measure? Summer 2009*
47	**Copyright statement/disclaimers:** Copyright © 2008 – Resolution Health, Inc. All rights reserved. The material submitted is confidential and proprietary. No use of this material is permitted other than in accordance with the Agreement with Measure Stewards between National Quality Forum and Resolution Health, Inc.
48	**Additional Information:** None
49	**I have checked that the submission is complete and any blank fields indicate that no information is provided.** ☒
50	**Date of Submission** (*MM/DD/YY*)**:** 7/9/09

PATIENT & FAMILY ENGAGEMENT

PRIORITY STATEMENT: Engage Patients and Their Families in Managing Their Health and Making Decisions About Their Care

1.1. All providers will routinely solicit and publicly report on their patients' perspectives of care

1.2. All providers will work collaboratively with their patients to assist them in making informed decisions about treatment options consistent with their values and preferences

POPULATION HEALTH

PRIORITY STATEMENT: IMPROVE THE HEALTH OF THE U.S. POPULATION

2.1. The population will be up to date on all high-priority age- and gender-appropriate evidence-based clinical preventive services

2.2. The population will receive recommended evidence-based interventions to improve targeted healthy lifestyle behaviors

2.3. All communities will demonstrate a 10% improvement in their community index of health

2.4. Americans will have all recommended high priority healthy lifestyle behaviors under control

SAFETY

PRIORITY STATEMENT: IMPROVE THE SAFETY OF THE U.S. HEALTH CARE SYSTEM

3.1. All providers will drive all preventable healthcare-associated infections (HAI) to zero

3.2. All providers will drive the incidence of preventable NQF Serious Reportable Events (SRE) to zero

3.3. All hospitals will reduce preventable and premature mortality rates to best-in-class

3.4. All hospitals and their community partners will reduce 30-day mortality rates following hospitalization for select conditions to best-in-class

PALLIATIVE CARE

PRIORITY STATEMENT: GUARANTEE APPROPRIATE AND COMPASSIONATE CARE FOR PATIENTS WITH LIFE-LIMITING ILLNESSES

4.1. All providers will identify, document, and effectively treat physical symptoms (e.g. pain, shortness of breath, constipation, others) at levels acceptable to patients with a life-limiting illness

4.2. All providers will effectively address the psychosocial and spiritual needs of patients with life-limiting illnesses and their families according to their preferences

4.3. All eligible patients will receive high quality palliative care and hospice services

CARE COORDINATION

PRIORITY STATEMENT: ENSURE PATIENTS RECEIVE WELL-COORDINATED CARE ACROSS ALL PROVIDERS, SETTINGS, AND LEVELS OF CARE

5.1. All providers will accurately and completely reconcile medications across the continuum of care (i.e. admission, transfer within and between care providers, discharge, and outpatient appointments) and ensure communication with the next provider of services

5.2. All inpatient and outpatient providers will assess the patient's perspective of the coordination of their care using a validated care coordination survey tool

5.3. All providers will reduce 30-day all-cause readmission rates resulting from poorly coordinated care to best-in-class

5.4. All providers will reduce preventable emergency department (i.e. those that could be avoided with timely access to primary care) visits resulting from poorly coordinated care by 50%

PATIENT-FOCUSED CARE

PRIORITY STATEMENT: GUARANTEE HIGH VALUE CARE ACROSS ACUTE AND CHRONIC EPISODES

6.1. All patients will receive high-value care over the course of their acute or chronic illness

OVERUSE

PRIORITY STATEMENT: ELIMINATE WASTE WHILE ENSURING THE DELIVERY OF APPROPRIATE CARE

7.1. Reduce wasteful and inappropriate care for the top ten targeted areas by 50%

THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0
August 2008

The measure information you submit will be shared with NQF's Steering Committees and Technical Advisory Panels to evaluate measures against the NQF criteria of importance to measure and report, scientific acceptability of measure properties, usability, and feasibility. Four conditions (as indicated below) must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards. Not all acceptable measures will be strong—or equally strong—among each set of criteria. The assessment of each criterion is a matter of degree; however, all measures must be judged to have met the first criterion, importance to measure and report, in order to be evaluated against the remaining criteria. References to the specific measure evaluation criteria are provided in parentheses following the item numbers. Please refer to the *Measure Evaluation Criteria* for more information at *www.qualityforum.org* under Core Documents. Additional guidance is being developed and when available will be posted on the NQF website.

Use the tab or arrow (↓→) keys to move the cursor to the next field (or back ←↑). There are three types of response fields:

- drop-down menus - select one response;
- check boxes – check as many as apply; and
- text fields – you can copy and paste text into these fields or enter text; these fields are not limited in size, but in most cases, we ask that you summarize the requested information.

Please note that URL hyperlinks do not work in the form; you will need to type them into your web browser.

Be sure to answer all questions. Fields that are left blank will be interpreted as no or none. Information must be provided in this form. Attachments are not allowed except when specifically requested or to provide additional detail or source documents for information that is summarized in this form. If you have important information that is not addressed by the questions, they can be entered into item #48 near the end of the form.

For questions about this form, please contact the NQF Project Director listed in the corresponding call for measures.

	CONDITIONS FOR CONSIDERATION BY NQF
	Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards.
A (A)	*Public domain or Intellectual Property Agreement signed: IP Agreement signed and submitted (If no, do not submit)* *Template for the Intellectual Property Agreement is available at www.qualityforum.org under Core Documents.*
B (B)	*Measure steward/maintenance: Is there an identified responsible entity and process to maintain and update the measure on a schedule commensurate with clinical innovation, but at least every 3 years? Yes, information provided in contact section (If no, do not submit)*
C (C)	*Intended use: Does the intended use of the measure include BOTH public reporting AND quality improvement? Yes (If no, do not submit)*
D (D)	*Fully developed and tested: Is the measure fully developed AND tested? Yes, fully developed and tested (If not tested and no plans for testing within 24 months, do not submit)*

THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0
August 2008

	(for NQF staff use) NQF Review #: EC-240-08 NQF Project: *National Voluntary Consensus Standards for Ambulatory Care Using Clinically Enriched Administrative Data*
	MEASURE SPECIFICATIONS & DESCRIPTIVE INFORMATION
1	*Information current as of (date- MM/DD/YY):* 06/25/09
2	*Title of Measure:* Breast Cancer -Cancer Surveillance
3	**Brief description of measure [1]:** Percentage of female patients with breast cancer who had breast cancer surveillance in the past 12 months
4 (2a)	**Numerator Statement:** Female patients with a history of breast cancer who had breast cancer surveillance **Time Window:** 12 months **Numerator Details** (Definitions, codes with description): see attached
5 (2a)	**Denominator Statement:** Female patients with a history of breast cancer **Time Window:** Anytime in the past **Denominator Details** (Definitions, codes with description): see attached
6 (2a, 2d)	**Denominator Exclusions:** Bilateral mastectomy in the past, bilateral breast implants, biopsy/excision of breast lesion General exclusions: • Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months; • Patients who have been in a skilled nursing facility in the last 3 months **Denominator Exclusion Details** (Definitions, codes with description): see attached
7 (2a, 2h)	**Stratification** Do the measure specifications require the results to be stratified? No ► If "other" describe: **Identification of stratification variable(s):** **Stratification Details** (Definitions, codes with description):
8 (2a,	**Risk Adjustment** Does the measure require risk adjustment to account for differences in patient severity before the onset of care? No ► **If yes,** (select one) ► Is there a separate proprietary owner of the risk model? (select one)

[1] Example of measure description: Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year.

2e)	**Identify Risk Adjustment Variables:** **Detailed risk model:** attached ☐ **OR** Web page URL:
9 (2a)	**Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☒ **OR** Web page URL: **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 ► If "Other", please describe:
10 (2a. 4a, 4b)	**Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** ICD9, CPT, pharmacy claims, patient derived data **Data dictionary/code table** attached ☒ **OR** Web page URL: **Data Quality** (2a) *Check all that apply* ☒ Data are captured from an authoritative/accurate source (e.g., lab values from laboratory personnel) ☒ Data are coded using recognized data standards ☒ Method of capturing data electronically fits the workflow of the authoritative source ☐ Data are available in EHRs ☐ Data are auditable
11 (2a, 4b)	**Data Source and Data Collection Methods** *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply* ☐ Electronic Health/Medical Record ☐ Electronic Clinical Database, Name: ☐ Electronic Clinical Registry, Name: ☒ Electronic Claims ☒ Electronic Pharmacy data ☐ Electronic Lab data ☐ Electronic source – other, Describe: ☐ Paper Medical Record ☐ Standardized clinical instrument, Name: ☐ Standardized patient survey, Name: ☐ Standardized clinician survey, Name: ☐ Other, Describe: Instrument/survey attached ☐ **OR** Web page URL:
12 (2a)	**Sampling** *If measure is based on a sample, provide instructions and guidance on sample size.* **Minimum sample size:** **Instructions:**
13 (2a)	**Type of Measure:** Process ► If "Other", please describe: ► If part of a composite or paired with another measure, please identify composite or paired measure
14 (2a)	**Unit of Measurement/Analysis** (*Who or what is being measured*) *Check all that apply.* ☒ Can be measured at all levels ☐ Individual clinician (e.g., physician, nurse) ☐ Group of clinicians (e.g., facility department/unit, group practice) ☐ Facility (e.g., hospital, nursing home) ☐ Integrated delivery system ☐ Health plan ☐ Community/Population ☐ Other (*Please describe*):
15 (2a)	**Applicable Care Settings** *Check all that apply* ☐ Can be used in all healthcare settings ☒ Ambulatory Care (office/clinic) ☐ Behavioral Healthcare ☒ Community Healthcare ☐ Dialysis Facility ☐ Emergency Department ☐ EMS emergency medical services ☒ Health Plan ☐ Home Health ☐ Hospice ☐ Hospital ☐ Long term acute care hospital ☒ Nursing home/ Skilled Nursing Facility (SNF) ☐ Prescription Drug Plan ☐ Rehabilitation Facility ☐ Substance Use Treatment Program/Center ☐ Other (*Please describe*):
	IMPORTANCE TO MEASURE AND REPORT

	Note: This is a threshold criterion. If a measure is not judged to be sufficiently important to measure and report, it will not be evaluated against the remaining criteria.
16 (1a)	**Addresses a Specific National Priority Partners Goal** *Enter the numbers of the specific goals related to this measure (see list of goals on last page)*: 2.1,2.2, 6.1
17 (1a)	**If not related to NPP goal, identify high impact aspect of healthcare** (select one) **Summary of Evidence:** **Citations[2] for Evidence:**
18 (1b)	**Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.* **Summary of Evidence:** Women with one primary breast cancer are at greater risk for developing a second primary breast cancer than the normal population. The probability of a metachronous tumor developing within 20 years of the primary tumor has been reported to be in the range of 15 percent. **Citations for Evidence:** CA Cancer J Clin - Ongoing Care of Patients After Primary Treatment for Their Cancer 2003;53:172-196
19 (1b)	**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.* **Summary of Evidence:** According to data from the NHIS, utilization of screening mammography has increased greatly among White and African American women of all ages since 1987. Among White women, the percentage of women age 40 and older who reported having had a mammogram within the past 2 years increased from 30% in 1987 to 71% in 2003. Similarly, during 1987 to 2003, the prevalence of mammography usage among African American women increased from 24% to 70%, respectively. Although current overall usage of mammography is similar among White and African American women, usage remains lower in women of other racial and ethnic groups.Women with less than a high school education, without health insurance coverage, or who are recent immigrants to the United States are even less likely to have had a recent mammogram. **Citations for evidence:** Trends in Breast Cancer by Race and Ethnicity: Update 2006 CA Cancer J Clin 2006; 56:168-183 2006 American Cancer Society
20 (1c)	**If measuring an Outcome** Describe relevance to the national health goal/priority, condition, population, and/or care being addressed: **If not measuring an outcome, provide evidence supporting this measure topic and grade the strength of the evidence** *Summarize the evidence (including citations to source) supporting the focus of the measure as follows:* • Intermediate outcome – evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit. • Process – evidence that the measured clinical or administrative process leads to improved health/avoidance of harm and if the measure focus is on one step in a multi-step care process, it measures the step that has the greatest effect on improving the specified desired outcome(s). • Structure – evidence that the measured structure supports the consistent delivery of effective processes or access that lead to improved health/avoidance of harm or cost/benefit. • Patient experience – evidence that an association exists between the measure of patient experience of health care and the outcomes, values and preferences of individuals/ the public. • Access – evidence that an association exists between access to a health service and the outcomes of, or experience with, care. • Efficiency– demonstration of an association between the measured resource use and level of

[2] Citations can include, but are not limited to journal articles, reports, web pages (URLs).

	performance with respect to one or more of the other five IOM aims of quality. **Type of Evidence** *Check all that apply* ☒ Evidence-based guideline ☐ Quantitative research studies ☐ Meta-analysis ☐ Qualitative research studies ☐ Systematic synthesis of research ☐ Other (*Please describe*): **Overall Grade for Strength of the Evidence**[3] (*Use the USPSTF system, or if different, also describe how it relates to the USPSTF system)*: Category 2B: there is uniform NCCN consensus, (but no major disagreement); based on lower level evidence including clinical experience,that the recommendation is appropriate. **Summary of Evidence** (*provide guideline information below*): Breast cancer can recur at any time, but most recurrences occur in the first three to five years after initial treatment. Surveillence mammograms are recommended once a year for follow up. Mammogram is recommended every 12 monhs unless treated with bilateral mastectomy. **Citations for Evidence:** CA Cancer J Clin - Ongoing Care of Patients After Primary Treatment for Their Cancer 2003;53:172-196; National Comprehensive Cancer Network Practice Guidelines in Oncology- Breast Cancer V2.2008. www.NCCN.org
21 (1c)	**Clinical Practice Guideline** *Cite the guideline reference; quote the specific guideline recommendation related to the measure and the guideline author's assessment of the strength of the evidence; and summarize the rationale for using this guideline over others.* **Guideline Citation:** National Comprehensive Cancer Network Practice Guidelines in Oncology- Breast Cancer V2.2008. www.NCCN.org **Specific guideline recommendation:** It is prudent that all women with a prior diagnosis of breast cancer have a yearly mammographic evaluation. Annual mammograms are indicated for the remainder of the patient's life. A Mammogram is recommended every 12 months unless postbilateral mastectomy in patients with a history of breast cancer. **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)*: Category 2B: there is uniform NCCN consensus, (but no major disagreement); based on lower level evidence including clinical experience,that the recommendation is appropriate. **Rationale for using this guideline over others:** Nationally recognized guideline in cancer
22 (1c)	**Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations*. **Summary:** **Citations:**
23 (1)	**Briefly describe how this measure (as specified) will facilitate significant gains in healthcare quality related to the specific priority goals and quality problems identified above:** The evidence supports regular history, physical examination, and mammography as the cornerstone of appropriate breast cancer follow-up. A yearly mammographic evaluation should be performed to detect cancer recurrence.
	SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

[3]The strength of the body of evidence for the specific measure focus should be systematically assessed and rated, e.g., USPSTF grading system www.ahrq.gov/clinic/uspstmeth.htm: A - The USPSTF recommends the service. There is high certainty that the net benefit is substantial. B - The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. C - The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. Offer or provide this service only if other considerations support the offering or providing the service in an individual patient. D - The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. I - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

	Note: Testing and results should be summarized in this form. However, additional detail and reports may be submitted as supplemental information or provided as a web page URL. If a measure has not been tested, it is only potentially eligible for time-limited endorsement.
24	**Supplemental Testing Information:** attached ☐ **OR** Web page URL:
25 (2b)	**Reliability Testing** **Data/sample:** **Analytic Method:** **Testing Results:**
26 (2c)	**Validity Testing** **Data/sample:** **Analytic Method:** **Testing Results:**
27 (2d)	**Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.* **Summary of Evidence supporting exclusion(s):** **Citations for Evidence:** **Data/sample:** **Analytic Method:** **Testing Results:**
28 (2e)	**Risk Adjustment Testing** *Summarize the testing used to determine the need (or no need) for risk adjustment and the statistical performance of the risk adjustment method.* **Data/sample:** **Analytic Method:** **Testing Results:** ►**If outcome or resource use measure not risk adjusted, provide rationale:**
29 (2g)	**Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*) **Data/sample:** **Analytic Method:** **Results:**
30 (2f)	**Provide Measure Results from Testing or Current Use** Results from testing **Data/sample:** We measured a commercial population of 459,196 members. **Methods to identify statistically significant and practically/meaningfully differences in performance:** Compliance to the performance measure is measured using an analysis of the claims data; in this case looking for evidence of breast cancer surveillance (e.g. mammograms). In addition, where appropriate we analyze patient data collected either from the patient's PHR or during a disease management program

	Results: We found that of the 1239 members who satisfied the denominator, 1123 were in the numerator, indicating a compliance rate of 91%
31 (2h)	**Identification of Disparities** ►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:** ►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale:
	USABILITY
32 (3)	*Current Use Testing completed If in use, how widely used Health plan or sytem ► If "other," please describe:* ☐ *Used in a public reporting initiative, name of initiative:* *Sample report attached* ☐ *OR Web page URL:*
33 (3a)	**Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **Data/sample:** Administrative claims database from health plans, patient derived data **Methods:** The performance measure is similar in message to a clinical alert that has been operational since 2002. Compliance to the clinical alert is measured using an analysis of subsequent claims, in this case the appearance of claims for a mammogram. In addition, a feedback tool accompanies every clinical alert message, and includes options indicating agreement or disagreement with the message. **Results:** In practice, fewer than 1% of the respondents disagreed with the medical literature, and more than 24% show objective evidence of compliance.
34 (3b, 3c)	**Relation to other NQF-endorsed™ measures** ►Is this measure similar or related to measure(s) already endorsed by NQF (on the same topic or the same target population)? *Measures can be found at www.qualityforum.org under Core Documents.* *Check all that apply* ☐ Have not looked at other NQF measures ☐ Other measure(s) on same topic ☐ Other measure(s) for same target population ☒ No similar or related measures **Name of similar or related NQF-endorsed™ measure(s):** **Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one) ►If not fully harmonized, provide rationale: **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:**
	FEASIBILITY
35 (4a)	*How are the required data elements generated? Check all that apply* ☒ *Data elements are generated concurrent with and as a byproduct of care processes during care delivery (e.g., blood pressure or other assessment recorded by personnel conducting the assessment)* ☐ *Data elements are generated from a patient survey (e.g., CAHPS)* ☒ *Data elements are generated through coding performed by someone other than the person who obtained the original information (e.g., DRG or ICD-9 coding on claims)* ☒ *Other, Please describe: Data obtained through electronic personal health records and telephonic, nurse-driven disease management programs*
36	*Electronic Sources All data elements* ►*If all data elements are not in electronic sources, specify the near-term path to electronic*

(4b)	*collection by most providers:* ►*Specify the data elements for the electronic health record:*
37 (4c)	*Do the specified exclusions require additional data sources beyond what is required for the other specifications?* No ►*If yes, provide justification:*
38 (4d)	*Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure:* *Generally, the use of claims data has inherent errors and inaccuracies related to incorrect coding, or missing data, which can result in less specificity in the definition of denominator and /or the numerator. To minimize these errors and inaccuracies, we use clinically enriched data (laboratory results, medication lists) to augment the claims data. In addition where possible, to corroborate the claims data, we solicit feedback from both providers via a feedback form and patients from a personal health record or from a disease management program.* *We do not anticipate significant unintended consequences from the implementation of the measure. Our measures are all developed from evidence-based literature or from clinical guidelines and are designed to encourage appropriate care of the patient.* *Describe how could these potential problems be audited: The inclusion of patient-derived data from a personal health record or through a disease management program may be used to confirm the presence or absence of a mammogram; ultimately the data sources may be tested against a sample of medical charts.* *Did you audit for these potential problems during testing?* No *If yes, provide results:*
39 (4e)	*Testing feasibility Describe what have you learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:* *Multiple sources of corroborating clinical data are necessary to correctly identify patients in the denominator. Earlier testing efforts using specifications similar to HEDIS were more sensitive yet nonspecific. The addition of supporting information for certain diagnostic conditions (e.g., diabetic medications and supplies in addition to ICD9 codes for diabetes) significantly decreased the number identified in the denominator, yet the analysis led to a much higher compliance rate, likely because of the exclusion of fewer false positives in the denominator.*
	CONTACT INFORMATION
40	*Web Page URL for Measure Information Describe where users (implementers) should go for more details on specifications of measures, or assistance in implementing the measure.* *Web page URL: www.activehealth.net*
41	**Measure Intellectual Property Agreement Owner Point of Contact** **First Name:** Madhavi **MI:** **Last Name:** Vemireddy **Credentials (MD, MPH, etc.):** MD **Organization:** ActiveHealth Management **Street Address:** 102 Madison Avenue **City:** New York **State:** NY **ZIP:** 10016 **Email:** mvemireddy@activehealth.net **Telephone:** 212-651-8200 ext:
42	**Measure Submission Point of Contact** **If different than IP Owner Contact** **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:** **Email:** **Telephone:** ext:
43	**Measure Developer Point of Contact** **If different than IP Owner Contact** **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:**

	Email: **Telephone:** ext:
44	**Measure Steward Point of Contact** **If different than IP Owner Contact** *Identifies the organization that will take responsibility for updating the measure and assuring it is consistent with the scientific evidence and current coding schema; the steward of the measure may be different than the developer.* **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:** **Email:** **Telephone:** ext
	ADDITIONAL INFORMATION
45	**Workgroup/Expert Panel involved in measure development** No workgroup or panel used ►If workgroup used, describe the members' role in measure development: ►Provide a list of workgroup/panel members' names and organizations:
46	*Measure Developer/Steward Updates and Ongoing Maintenance* *Year the measure was first released: 2002* *Month and Year of most recent revision: 02/2009* *What is the frequency for review/update of this measure? Biennially* *When is the next scheduled review/update for this measure? 2011*
47	**Copyright statement/disclaimers:** This information, including any attachments hereto, is the sole, exclusive, proprietary and confidential property of Active Health Management, Inc., and is for the exclusive use of The National Quality Forum. Any use, copying, disclosure, dissemination or distribution by anyone other than the National Quality Forum is strictly prohibited.
48	**Additional Information:**
49	**I have checked that the submission is complete and any blank fields indicate that no information is provided.** ☒
50	**Date of Submission** (*MM/DD/YY*)**:** 02/09/09

PATIENT & FAMILY ENGAGEMENT

PRIORITY STATEMENT: Engage Patients and Their Families in Managing Their Health and Making Decisions About Their Care

1.1. All providers will routinely solicit and publicly report on their patients' perspectives of care

1.2. All providers will work collaboratively with their patients to assist them in making informed decisions about treatment options consistent with their values and preferences

POPULATION HEALTH

PRIORITY STATEMENT: IMPROVE THE HEALTH OF THE U.S. POPULATION

2.1. The population will be up to date on all high-priority age- and gender-appropriate evidence-based clinical preventive services

2.2. The population will receive recommended evidence-based interventions to improve targeted healthy lifestyle behaviors

2.3. All communities will demonstrate a 10% improvement in their community index of health

2.4. Americans will have all recommended high priority healthy lifestyle behaviors under control

SAFETY

PRIORITY STATEMENT: IMPROVE THE SAFETY OF THE U.S. HEALTH CARE SYSTEM

3.1. All providers will drive all preventable healthcare-associated infections (HAI) to zero

3.2. All providers will drive the incidence of preventable NQF Serious Reportable Events (SRE) to zero

3.3. All hospitals will reduce preventable and premature mortality rates to best-in-class

3.4. All hospitals and their community partners will reduce 30-day mortality rates following hospitalization for select conditions to best-in-class

PALLIATIVE CARE

PRIORITY STATEMENT: GUARANTEE APPROPRIATE AND COMPASSIONATE CARE FOR PATIENTS WITH LIFE-LIMITING ILLNESSES

4.1. All providers will identify, document, and effectively treat physical symptoms (e.g. pain, shortness of breath, constipation, others) at levels acceptable to patients with a life-limiting illness

4.2. All providers will effectively address the psychosocial and spiritual needs of patients with life-limiting illnesses and their families according to their preferences

4.3. All eligible patients will receive high quality palliative care and hospice services

CARE COORDINATION

PRIORITY STATEMENT: ENSURE PATIENTS RECEIVE WELL-COORDINATED CARE ACROSS ALL PROVIDERS, SETTINGS, AND LEVELS OF CARE

5.1. All providers will accurately and completely reconcile medications across the continuum of care (i.e. admission, transfer within and between care providers, discharge, and outpatient appointments) and ensure communication with the next provider of services

5.2. All inpatient and outpatient providers will assess the patient's perspective of the coordination of their care using a validated care coordination survey tool

5.3. All providers will reduce 30-day all-cause readmission rates resulting from poorly coordinated care to best-in-class

5.4. All providers will reduce preventable emergency department (i.e. those that could be avoided with timely access to primary care) visits resulting from poorly coordinated care by 50%

PATIENT-FOCUSED CARE

PRIORITY STATEMENT: GUARANTEE HIGH VALUE CARE ACROSS ACUTE AND CHRONIC EPISODES

6.1. All patients will receive high-value care over the course of their acute or chronic illness

OVERUSE

PRIORITY STATEMENT: ELIMINATE WASTE WHILE ENSURING THE DELIVERY OF APPROPRIATE CARE

7.1. Reduce wasteful and inappropriate care for the top ten targeted areas by 50%

PERFORMANCE MEASURE RULE:
Breast Cancer - Cancer Surveillance

DENOMINATOR

All of the following are correct:

1. Patient Age ≥ 18 Years and Female
2. Breast Cancer Validation is confirmed for the member (see below)

DENOMINATOR EXCLUSIONS

One of the following is correct:

1. Presence of Patient Data Confirming At Least 1 PDD- MASTECTOMY BILATERAL In the past
2. Presence of At Least 1 MASTECTOMY BILATERAL Procedure In the past
3. Presence of At Least 1 BILATERAL BREAST IMPLANT Procedure In the past
4. Presence of At Least 1 MASTECTOMY UNILATERAL Procedure in the past 15 Months
5. Presence of At Least 2 MASTECTOMY UNILATERAL Procedures anytime in the past
6. Presence of At Least 1 CHEMOTHERAPY/RADIATION THERAPY Procedure In the past 15 Months
7. Presence of At Least 1BIOPSY/EXCISION OF BREAST LESION Procedure in the past 15 Months

NUMERATOR

All of the following are correct:

1. Denominator is true
2. One of the following is correct:
    a. Presence of At Least 1 MAMMOGRAM (ICD-9) Diagnosis in the past 12 Months
    b. Presence of At Least 1 MAMMOGRAM Procedure in the past 12 Months
    b. Presence of Patient Data Confirming At Least 1 PDD- MAMMOGRAM 1 YR OBS in the past 6 Months

d. Presence of At Least 1 BREAST PET SCAN Procedure in the past 12 Months

e. Presence of at Least 1 BREAST MRI in the past 12 Months

Breast Cancer Validation

One of the following expressions is correct:

1. Presence of At Least 2 CANCER BREAST Diagnostic that overlaps with at least 1 CHEMOTHERAPY/RADIATION THERAPY Procedure in the past

2. Presence of At Least 1 CANCER BREAST Diagnostic that overlaps with at least 1 MASTECTOMY UNILATERAL Procedure in the past

3. Presence of At Least 2 CANCER BREAST Diagnostic that overlaps with at least 1Refill CHEMOTHERAPY Drug in the past

4. Presence of At Least 4 CANCER BREAST Diagnosis in the past 3 Years and a current refill of BREAST CA HORMONAL THERAPY that overlaps with at least 1 CANCER BREAST Diagnosis

5. Presence of Patient Data Confirming At Least 1 PDD- BREAST CANCER Result In the past

Note: A current refill is defined as a refill in which the day supply of a drug extends into the end of the measurement window plus a grace period of 30 days.

Note: A 3 month time window has been added to certain timeframes in order to account for the inherent delay in the acquisition of administrative claims data.

THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0
August 2008

The measure information you submit will be shared with NQF's Steering Committees and Technical Advisory Panels to evaluate measures against the NQF criteria of importance to measure and report, scientific acceptability of measure properties, usability, and feasibility. Four conditions (as indicated below) must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards. Not all acceptable measures will be strong—or equally strong—among each set of criteria. The assessment of each criterion is a matter of degree; however, all measures must be judged to have met the first criterion, importance to measure and report, in order to be evaluated against the remaining criteria. References to the specific measure evaluation criteria are provided in parentheses following the item numbers. Please refer to the *Measure Evaluation Criteria* for more information at *www.qualityforum.org* under Core Documents. Additional guidance is being developed and when available will be posted on the NQF website.

Use the tab or arrow (↓→) keys to move the cursor to the next field (or back ←↑). There are three types of response fields:

- drop-down menus - select one response;
- check boxes – check as many as apply; and
- text fields – you can copy and paste text into these fields or enter text; these fields are not limited in size, but in most cases, we ask that you summarize the requested information.

Please note that URL hyperlinks do not work in the form; you will need to type them into your web browser.

Be sure to answer all questions. Fields that are left blank will be interpreted as no or none. Information must be provided in this form. Attachments are not allowed except when specifically requested or to provide additional detail or source documents for information that is summarized in this form. If you have important information that is not addressed by the questions, they can be entered into item #48 near the end of the form.

For questions about this form, please contact the NQF Project Director listed in the corresponding call for measures.

	CONDITIONS FOR CONSIDERATION BY NQF
	Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards.
A (A)	*Public domain or Intellectual Property Agreement signed: IP Agreement signed and submitted (If no, do not submit)* *Template for the Intellectual Property Agreement is available at www.qualityforum.org under Core Documents.*
B (B)	*Measure steward/maintenance: Is there an identified responsible entity and process to maintain and update the measure on a schedule commensurate with clinical innovation, but at least every 3 years? Yes, information provided in contact section (If no, do not submit)*
C (C)	*Intended use: Does the intended use of the measure include BOTH public reporting AND quality improvement? Yes (If no, do not submit)*
D (D)	*Fully developed and tested: Is the measure fully developed AND tested? Yes, fully developed and tested (If not tested and no plans for testing within 24 months, do not submit)*

THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0
August 2008

	(for NQF staff use) NQF Review #: EC-248-08 NQF Project: *National Voluntary Consensus Standards for Ambulatory Care Using Clinically Enriched Administrative Data*
	MEASURE SPECIFICATIONS & DESCRIPTIVE INFORMATION
1	*Information current as of (date- MM/DD/YY):* 06/25/09
2	*Title of Measure:* Prostate Cancer - Cancer Surveillance
3	**Brief description of measure [1]:** Percentage of males with prostate cancer that have had their PSA monitored in the past 12 months
4 (2a)	**Numerator Statement:** Patients that have had PSA monitoring **Time Window:** 12 months **Numerator Details** (Definitions, codes with description): see attached
5 (2a)	**Denominator Statement:** All men diagnosed with prostate cancer **Time Window:** All available historical data for the presence of prostate cancer **Denominator Details** (Definitions, codes with description): see attached
6 (2a, 2d)	**Denominator Exclusions:** 1. Specific exclusions: • Evidence of a workup for prostate disease in monitoring timefram • Prostate cancer treatment in monitoring timeframe • Prostate ultasound in monitoring timeframe 2. General exclusions: • Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months; • Patients who have been in a skilled nursing facility in the last 3 months **Denominator Exclusion Details** (Definitions, codes with description): see attached
7 (2a, 2h)	**Stratification** Do the measure specifications require the results to be stratified? No ► If "other" describe: **Identification of stratification variable(s):** **Stratification Details** (Definitions, codes with description):
8	**Risk Adjustment** Does the measure require risk adjustment to account for differences in patient

[1] Example of measure description: Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year.

(2a, 2e)	severity before the onset of care? No ► **If yes,** (select one) ► Is there a separate proprietary owner of the risk model? (select one) **Identify Risk Adjustment Variables:** **Detailed risk model:** attached ☐ **OR** Web page URL:
9 (2a)	**Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☒ **OR** Web page URL: **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 ► If "Other", please describe:
10 (2a. 4a, 4b)	**Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** ICD9, CPT, pharmacy claims, lab values, patient-derived information **Data dictionary/code table** attached ☒ **OR** Web page URL: **Data Quality** (2a) *Check all that apply* ☒ Data are captured from an authoritative/accurate source (e.g., lab values from laboratory personnel) ☒ Data are coded using recognized data standards ☒ Method of capturing data electronically fits the workflow of the authoritative source ☐ Data are available in EHRs ☐ Data are auditable
11 (2a, 4b)	**Data Source and Data Collection Methods** *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply* ☐ Electronic Health/Medical Record ☐ Electronic Clinical Database, Name: ☐ Electronic Clinical Registry, Name: ☒ Electronic Claims ☒ Electronic Pharmacy data ☒ Electronic Lab data ☐ Electronic source – other, Describe: ☐ Paper Medical Record ☐ Standardized clinical instrument, Name: ☐ Standardized patient survey, Name: ☐ Standardized clinician survey, Name: ☐ Other, Describe: Instrument/survey attached ☐ **OR** Web page URL:
12 (2a)	**Sampling** *If measure is based on a sample, provide instructions and guidance on sample size.* **Minimum sample size:** **Instructions:**
13 (2a)	**Type of Measure:** Process ► If "Other", please describe: ► If part of a composite or paired with another measure, please identify composite or paired measure
14 (2a)	**Unit of Measurement/Analysis** (*Who or what is being measured*) *Check all that apply.* ☒ Can be measured at all levels ☐ Individual clinician (e.g., physician, nurse) ☐ Group of clinicians (e.g., facility department/unit, group practice) ☐ Facility (e.g., hospital, nursing home) ☐ Integrated delivery system ☐ Health plan ☐ Community/Population ☐ Other (*Please describe*):
15 (2a)	**Applicable Care Settings** *Check all that apply* ☐ Can be used in all healthcare settings ☒ Ambulatory Care (office/clinic) ☐ Behavioral Healthcare ☒ Community Healthcare ☐ Dialysis Facility ☐ Emergency Department ☐ EMS emergency medical services ☒ Health Plan ☐ Home Health ☐ Hospice ☐ Hospital ☐ Long term acute care hospital ☒ Nursing home/ Skilled Nursing Facility (SNF) ☐ Prescription Drug Plan ☐ Rehabilitation Facility ☐ Substance Use Treatment Program/Center ☐ Other (*Please describe*):

	IMPORTANCE TO MEASURE AND REPORT
	Note: This is a threshold criterion. If a measure is not judged to be sufficiently important to measure and report, it will not be evaluated against the remaining criteria.
16 (1a)	**Addresses a Specific National Priority Partners Goal** *Enter the numbers of the specific goals related to this measure (see list of goals on last page)*: 2.1,2.2, 6.1
17 (1a)	**If not related to NPP goal, identify high impact aspect of healthcare** (select one) **Summary of Evidence:** **Citations[2] for Evidence:**
18 (1b)	**Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.* **Summary of Evidence:** National Comprehensive Cancer Network Practice Guidelines in Oncology - Prostate Cancer An estimated 218 890 U.S. men received a prostate cancer diagnosis in 2007, and 1 of 6 men in the U.S. will receive the diagnosis in his lifetime. An estimated 27,350 men died of prostate cancer in the United States in 2006.1 The median age of death from prostate cancer from 2000 through 2004 was 80 years, and 71% of deaths occurred in men older than 75 years. African-American men have a substantially higher prostate cancer incidence rate than white men (217.5 vs. 134.5 cases per 100 000 men) and more than twice the prostate cancer mortality rate of white men (56.1 vs. 23.4 deaths per 100 000 men). In our book of business experience for 2008, a total of 10752 clinical alerts were sent to members who have had prostate cancer and did not have PSA in monitoring timeframe. **Citations for Evidence:** National Comprehensive Cancer Network Practice Guidelines in Oncology - Prostate Cancer v1.2009
19 (1b)	**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.* **Summary of Evidence:** Prostate cancer remains the most common cancer in American men. African-American men continue to have higher prostate cancer prevalence and mortality rates compared to men in other populations. African-American men are 40 percent more likely to have prostate cancer and twice as likely as white men to die of the disease. In 1993, African-American Medicare beneficiaries were almost 2.5 times as likely their white counterparts to have a bi-lateral orchiectomy (surgery to remove the testicles) to treat prostate cancer…Between 1996-2003, the five-year relative survival rate for black men diagnosed with prostate cancer was nearly 95 percent compared to almost 99 percent for white men. The factors that influence prostate cancer health disparities are still not well understood. Age is the most important risk factor for contracting prostate cancer. Others are race, family history, and environment. Environmental factors likely account for the prostate cancers found in men with no family history, including geographic location, a high-fat diet, high caloric intake, and a sedentary lifestyle **Citations for evidence:** Health Disparities - Prostate Cancer; http://ncmhd.nih.gov/hdFactSheet_pc.asp
20 (1c)	**If measuring an Outcome** Describe relevance to the national health goal/priority, condition, population, and/or care being addressed: **If not measuring an outcome, provide evidence supporting this measure topic and grade the strength of the evidence** *Summarize the evidence (including citations to source) supporting the focus of the measure as follows:* • Intermediate outcome – evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit.

[2] Citations can include, but are not limited to journal articles, reports, web pages (URLs).

	• Process – evidence that the measured clinical or administrative process leads to improved health/avoidance of harm and if the measure focus is on one step in a multi-step care process, it measures the step that has the greatest effect on improving the specified desired outcome(s). • Structure – evidence that the measured structure supports the consistent delivery of effective processes or access that lead to improved health/avoidance of harm or cost/benefit. • Patient experience – evidence that an association exists between the measure of patient experience of health care and the outcomes, values and preferences of individuals/ the public. • Access – evidence that an association exists between access to a health service and the outcomes of, or experience with, care. • Efficiency– demonstration of an association between the measured resource use and level of performance with respect to one or more of the other five IOM aims of quality. **Type of Evidence** *Check all that apply* ☒ Evidence-based guideline ☐ Quantitative research studies ☐ Meta-analysis ☐ Qualitative research studies ☐ Systematic synthesis of research ☐ Other (*Please describe*): **Overall Grade for Strength of the Evidence**[3] (*Use the USPSTF system, or if different, also describe how it relates to the USPSTF system)*: B - Using the USPSTF system. It is recommended that clinicians routinely follow the guideline for eligible patients. There is moderate evidence that the practice improves net health outcomes. **Summary of Evidence** (*provide guideline information below*): Although randomized trial data confirming a reduction in mortality as a result of testing are not yet available, the consensus of the workshop participants was that evidence indicating a benefit from testing is significantly stronger today than it was in 1997…Recent analysis of the National Cancer Institute's (NCI) Surveillance Epidemiology, and End Results (SEER) data shows that prostate cancer mortality in white men younger than age 85 has declined to levels below those that existed prior to the PSA era, which began about 1986.6 In fact, for men ages 60 to 79, mortality rates in 1997 were lower than in any year since 1950. Since it is distant-stage disease that is significantly more likely to be fatal in the near term compared with regional disease, the obser-vation that incidence rates of distant disease were declining while local and regional disease incidence rates were increasing is highly suggestive of a screening effect. They observed that the recent decline in mortality is associated with a decline in the incidence rate of advanced disease, and especially with an increase in the detection of organ-confined (i.e., non-metastatic), high-grade disease. **Citations for Evidence:** American Cancer Society Guidelines for the Early Detection of Cancer: Update of Early Detection Guidelines for Prostate, Colorectal, and Endometrial Cancers; Author(s): Robert A. Smith, PhD, Andrew C. von Eschenbach, MD, Richard Wender, MD (for The Acs Prostate Cancer Advisory Committee), Bernard Levin, MD, Tim Byers, MD, David Rothenberger, MD, Durado Brooks, MD (for The Acs Colorectal Cancer Advisory Committee), William Creasman, MD, Carmel Cohen, MD, Carolyn Runowicz, MD, Debbie Saslow, MD, PhD (for the ACS Endometrial Cancer Advisory Committee), Vilma Cokkinides, PhD, Harmon Eyre, MD; RECENT DATA ON PROSTATE CANCER TESTING FOR EARLY DETECTION ;CA Cancer J Clin 2001; 51:38
21 (1c)	**Clinical Practice Guideline** *Cite the guideline reference; quote the specific guideline recommendation related to the measure and the guideline author's assessment of the strength of the evidence; and summarize the rationale for using this guideline over others.* **Guideline Citation:** National Comprehensive Cancer Network Practice Guidelines in Oncology - Prostate

[3]The strength of the body of evidence for the specific measure focus should be systematically assessed and rated, e.g., USPSTF grading system www.ahrq.gov/clinic/uspstmeth.htm: A - The USPSTF recommends the service. There is high certainty that the net benefit is substantial. B - The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. C - The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. Offer or provide this service only if other considerations support the offering or providing the service in an individual patient. D - The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. I - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

	Cancer v1.2009 (**Specific guideline recommendation:** For patients initially treated with intent to cure, a serum PSA level should be measured every 6-12 months for the first 5 years and then rechecked annually. **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF*)**:** The authors did not rate their recommendations **Rationale for using this guideline over others:** Nationally recognized guideline in oncology
22 (1c)	**Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.* **Summary:** In men younger than age 75 years, the USPSTF found inadequate evidence to determine whether treatment for prostate cancer detected by screening improves health outcomes compared with treatment after clinical detection…Even if prostate cancer screening is determined to be effective, the length of time required to experience a mortality benefit is greater than 10 years. Because a 75-year-old man has an average life expectancy of about 10 years, very few men age 75 years or older would experience a mortality benefit. Similarly, men younger than age 75 years who have chronic medical problems and a life expectancy of fewer than 10 years are also unlikely to benefit from screening and treatment. Harms of Detection and Early Treatment The USPSTF found convincing evidence that treatment for prostate cancer detected by screening causes moderate-to-substantial harms, such as erectile dysfunction, urinary incontinence, bowel dysfunction, and death. These harms are especially important because some men with prostate cancer who are treated would never have developed symptoms related to cancer during their lifetime. There is also adequate evidence that the screening process produces at least small harms, including pain and discomfort associated with prostate biopsy and psychological effects of false-positive test results…Prostate cancer is a clinically heterogeneous disease. A substantial proportion of prostate cancer cases detected with current screening methods will never cause symptoms during the patients' lifetime. Modeling studies based on U.S. incidence data suggest overdiagnosis rates ranging from 29% to 44% of all prostate cancer cases detected by PSA screening.10 Because patients with "pseudo-disease" receive no benefit from, and may be harmed by, prostate cancer screening and treatment, prostate cancer detection in this population constitutes an important burden. **Citations:** U.S. Preventive Services Task Force. Screening for Prostate Cancer: U.S. Preventive Services Task Force Recommendation Statement. AHRQ Publication No. 08-05121-EF-2, August 2008
23 (1)	**Briefly describe how this measure (as specified) will facilitate significant gains in healthcare quality related to the specific priority goals and quality problems identified above:** PSA monitoring in patients with prostate cancer may decrease the risk of disease progression and reduce subsequent complications and costs.
	SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES
	Note: Testing and results should be summarized in this form. However, additional detail and reports may be submitted as supplemental information or provided as a web page URL. If a measure has not been tested, it is only potentially eligible for time-limited endorsement.
24	**Supplemental Testing Information:** attached ☐ **OR** Web page URL:
25 (2b)	**Reliability Testing** **Data/sample:** **Analytic Method:**

	Testing Results:
26 (2c)	**Validity Testing** **Data/sample:** **Analytic Method:** **Testing Results:**
27 (2d)	**Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.* **Summary of Evidence supporting exclusion(s):** **Citations for Evidence:** **Data/sample:** **Analytic Method:** **Testing Results:**
28 (2e)	**Risk Adjustment Testing** *Summarize the testing used to determine the need (or no need) for risk adjustment and the statistical performance of the risk adjustment method.* **Data/sample:** **Analytic Method:** **Testing Results:** ►**If outcome or resource use measure not risk adjusted, provide rationale:**
29 (2g)	**Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*) **Data/sample:** **Analytic Method:** **Results:**
30 (2f)	**Provide Measure Results from Testing or Current Use** Results from testing **Data/sample:** We measured a commercial population of 459,196 members. **Methods to identify statistically significant and practically/meaningfully differences in performance:** Compliance to the performance measure is measured using an analysis of the claims data; in this case looking for evidence of PSA monitoring. In addition, where appropriate we analyze patient data collected either from the patient's PHR or during a disease management program. **Results:** We found that of the 1235 members who satisfied the denominator, 854 were in the numerator, indicating a compliance rate of 69%.
31 (2h)	**Identification of Disparities** ►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:** ►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale:
	USABILITY

32 (3)	*Current Use Testing completed If in use, how widely used Health plan or sytem ► If "other," please describe:* ☐ *Used in a public reporting initiative, name of initiative:* *Sample report attached* ☐ *OR Web page URL:*
33 (3a)	**Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **Data/sample:** Administrative claims database from health plans; lab results data; patient derived data. **Methods:** The performance measure is similar in message to a clinical alert that has been operational since 2003. Compliance to the clinical alert is measured using an analysis of subsequent claims, in this case the appearance of procedure (CPT) claims for PSA monitoring. In addition, a feedback tool accompanies every clinical alert message, and includes options indicating agreement or disagreement with the message. **Results:** In practice, fewer than 1% of the respondents disagreed with the medical literature, and more than 16% show objective evidence of compliance with the clinical alert.
34 (3b, 3c)	**Relation to other NQF-endorsed™ measures** ►Is this measure similar or related to measure(s) already endorsed by NQF (on the same topic or the same target population)? *Measures can be found at www.qualityforum.org under Core Documents.* *Check all that apply* ☐ Have not looked at other NQF measures ☐ Other measure(s) on same topic ☐ Other measure(s) for same target population ☒ No similar or related measures **Name of similar or related NQF-endorsed™ measure(s):** **Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one) ►If not fully harmonized, provide rationale: **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** The computerized data elements and rule algorithms employed by the proposed measure will allow the analysis of large populations to identify individuals appropriate for the measure. Other case-finding methodologies have been limited by the need for chart review and data abstraction.
	FEASIBILITY
35 (4a)	*How are the required data elements generated? Check all that apply* ☒ *Data elements are generated concurrent with and as a byproduct of care processes during care delivery (e.g., blood pressure or other assessment recorded by personnel conducting the assessment)* ☐ *Data elements are generated from a patient survey (e.g., CAHPS)* ☒ *Data elements are generated through coding performed by someone other than the person who obtained the original information (e.g., DRG or ICD-9 coding on claims)* ☒ *Other, Please describe: Data obtained through electronic personal health records and telephonic, nurse-driven disease management programs*
36 (4b)	*Electronic Sources All data elements* ►*If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:* ►*Specify the data elements for the electronic health record:*
37 (4c)	*Do the specified exclusions require additional data sources beyond what is required for the other specifications? No* ►*If yes, provide justification:*
38	*Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure: Generally, the use of claims data has inherent errors and inaccuracies related to incorrect coding, or*

(4d)	*missing data, which can result in less specificity in the definition of denominator and /or the numerator. To minimize these errors and inaccuracies, we use clinically enriched data (laboratory results, medication lists) to augment the claims data. In addition where possible, to corroborate the claims data, we solicit feedback from both providers via a feedback form and patients from a personal health record or from a disease management program.* *We do not anticipate significant unintended consequences from the implementation of the measure. Our measures are all developed from evidence-based literature or from clinical guidelines and are designed to encourage appropriate care of the patient.* *Describe how could these potential problems be audited: The inclusion of patient-derived data from a personal health record or through a disease management program may be used to confirm the presence or absence of a medication; ultimately the data sources may be tested against a sample of medical charts.* *Did you audit for these potential problems during testing? No If yes, provide results:*
39 (4e)	*Testing feasibility Describe what have you learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: Multiple sources of corroborating clinical data are necessary to correctly identify patients in the denominator. Earlier testing efforts using specifications similar to HEDIS were more sensitive yet nonspecific. The addition of supporting information for certain diagnostic conditions (e.g., diabetic medications and supplies in addition to ICD9 codes for diabetes) significantly decreased the number identified in the denominator, yet the analysis led to a much higher compliance rate, likely because of the exclusion of fewer false positives in the denominator.*
	CONTACT INFORMATION
40	*Web Page URL for Measure Information Describe where users (implementers) should go for more details on specifications of measures, or assistance in implementing the measure.* *Web page URL: www.activehealth.net*
41	**Measure Intellectual Property Agreement Owner Point of Contact** **First Name:** Madhavi **MI:** **Last Name:** Vemireddy **Credentials (MD, MPH, etc.):** MD **Organization:** ActiveHealth Management **Street Address:** 102 Madison Avenue **City:** New York **State:** NY **ZIP:** 10016 **Email:** mvemireddy@activehealth.net **Telephone:** 212-651-8200 ext:
42	**Measure Submission Point of Contact** **If different than IP Owner Contact** **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:** **Email:** **Telephone:** ext:
43	**Measure Developer Point of Contact** **If different than IP Owner Contact** **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:** **Email:** **Telephone:** ext:
44	**Measure Steward Point of Contact** **If different than IP Owner Contact** *Identifies the organization that will take responsibility for updating the measure and assuring it is consistent with the scientific evidence and current coding schema; the steward of the measure may be different than the developer.* **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:** **Email:** **Telephone:** ext

	ADDITIONAL INFORMATION
45	**Workgroup/Expert Panel involved in measure development** No workgroup or panel used ►If workgroup used, describe the members' role in measure development: ►Provide a list of workgroup/panel members' names and organizations:
46	*Measure Developer/Steward Updates and Ongoing Maintenance* *Year the measure was first released: 2003* *Month and Year of most recent revision: 3/2009* *What is the frequency for review/update of this measure? Biennially* *When is the next scheduled review/update for this measure? 2011*
47	**Copyright statement/disclaimers:** This information, including any attachments hereto, is the sole, exclusive, proprietary and confidential property of Active Health Management, Inc., and is for the exclusive use of The National Quality Forum. Any use, copying, disclosure, dissemination or distribution by anyone other than the National Quality Forum is strictly prohibited.
48	**Additional Information:**
49	**I have checked that the submission is complete and any blank fields indicate that no information is provided.** ☒
50	**Date of Submission** (*MM/DD/YY*)**:** 02/09/2009

PATIENT & FAMILY ENGAGEMENT

PRIORITY STATEMENT: Engage Patients and Their Families in Managing Their Health and Making Decisions About Their Care

1.1. All providers will routinely solicit and publicly report on their patients' perspectives of care

1.2. All providers will work collaboratively with their patients to assist them in making informed decisions about treatment options consistent with their values and preferences

POPULATION HEALTH

PRIORITY STATEMENT: IMPROVE THE HEALTH OF THE U.S. POPULATION

2.1. The population will be up to date on all high-priority age- and gender-appropriate evidence-based clinical preventive services

2.2. The population will receive recommended evidence-based interventions to improve targeted healthy lifestyle behaviors

2.3. All communities will demonstrate a 10% improvement in their community index of health

2.4. Americans will have all recommended high priority healthy lifestyle behaviors under control

SAFETY

PRIORITY STATEMENT: IMPROVE THE SAFETY OF THE U.S. HEALTH CARE SYSTEM

3.1. All providers will drive all preventable healthcare-associated infections (HAI) to zero

3.2. All providers will drive the incidence of preventable NQF Serious Reportable Events (SRE) to zero

3.3. All hospitals will reduce preventable and premature mortality rates to best-in-class

3.4. All hospitals and their community partners will reduce 30-day mortality rates following hospitalization for select conditions to best-in-class

PALLIATIVE CARE

PRIORITY STATEMENT: GUARANTEE APPROPRIATE AND COMPASSIONATE CARE FOR PATIENTS WITH LIFE-LIMITING ILLNESSES

4.1. All providers will identify, document, and effectively treat physical symptoms (e.g. pain, shortness of breath, constipation, others) at levels acceptable to patients with a life-limiting illness

4.2. All providers will effectively address the psychosocial and spiritual needs of patients with life-limiting illnesses and their families according to their preferences

4.3. All eligible patients will receive high quality palliative care and hospice services

CARE COORDINATION

PRIORITY STATEMENT: ENSURE PATIENTS RECEIVE WELL-COORDINATED CARE ACROSS ALL PROVIDERS, SETTINGS, AND LEVELS OF CARE

5.1. All providers will accurately and completely reconcile medications across the continuum of care (i.e. admission, transfer within and between care providers, discharge, and outpatient appointments) and ensure communication with the next provider of services

5.2. All inpatient and outpatient providers will assess the patient's perspective of the coordination of their care using a validated care coordination survey tool

5.3. All providers will reduce 30-day all-cause readmission rates resulting from poorly coordinated care to best-in-class

5.4. All providers will reduce preventable emergency department (i.e. those that could be avoided with timely access to primary care) visits resulting from poorly coordinated care by 50%

PATIENT-FOCUSED CARE

PRIORITY STATEMENT: GUARANTEE HIGH VALUE CARE ACROSS ACUTE AND CHRONIC EPISODES

6.1. All patients will receive high-value care over the course of their acute or chronic illness

OVERUSE

PRIORITY STATEMENT: ELIMINATE WASTE WHILE ENSURING THE DELIVERY OF APPROPRIATE CARE

7.1. Reduce wasteful and inappropriate care for the top ten targeted areas by 50%

PERFORMANCE MEASURE RULE:
Prostate Cancer - Cancer Surveillance

DENOMINATOR

All of the following are correct:

1. Patient gender is male
2. One of the following is correct:
    a. Presence of at least 2 CANCER PROSTATE diagnostic code in the past that overlaps with at least 1 PROSTATE CANCER TREATMENT procedure
    b. Presence of at least 4 CANCER PROSTATE diagnosis in the past at least 1 month apart

DENOMINATOR EXCLUSIONS

One of the following is correct:

1. Presence of at least 1 PROSTATE CANCER TREATMENT procedure in the past 12 months

NUMERATOR

All of the following are correct:
2. Denominator is true
3. One of the following is correct:
    a. Presence of at least 1 PSA CPT procedure in the past 12 months
    b. Presence of at least 1 ELEVATED PSA diagnosis in the past 12 months
    c. Presence of at least 1 PSA LAB in the past 12 months
    d. Presence of patient data confirming at least 1 PDD- PSA SURVEILLANCE in the past 12 months

Note: A 3 month time window has been added to certain timeframes in order to account for the inherent delay in the acquisition of administrative claims data.

Note: A current refill is defined as a refill in which the day supply of a drug extends into the end of the measurement window plus a grace period of 30 days.