# 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 |
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| | *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)*<br>*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)* |

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## MEASURE SUBMISSION FORM VERSION 3.0
August 2008

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| | *(for NQF staff use) NQF Review #: EC-027-08 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): 6/19/09* |
| **2** | *Title of Measure: Ambulatory initiated Amiodarone Therapy: TSH Test* |
| **3** | **Brief description of measure [1]:** This measure identifies the percentage of patients who had a TSH baseline measurement at the start of amiodarone therapy |
| **4** (2a) | **Numerator Statement:** Patients in the denominator who had TSH baseline measurement within 60 days prior to or 30 days after the amiodarone start date<br><br>**Time Window:** See below<br><br>**Numerator Details** (Definitions, codes with description): - >=1 claim for 'Thyroid Stimulating Hormone' test (see procedure codes below) during the period of 60 days prior to amiodarone start date (see denominator details below) to 30 days after the amiodarone start date<br><br>Thyroid Stimulating Hormone (Procedure)<br>Type Code Description<br>CPT4 80050 GENERAL HEALTH PANEL<br>CPT4 80418 COMBO RAPID PITUITARY EVAL PANEL<br>CPT4 80438 THYROTROPIN RELEAS HORMON STIM; 1HR<br>CPT4 80439 THYROTROPIN RELEAS HORMON STIM; 2HR<br>CPT4 80440 THYROTROP RELEAS HORMON; HYPERPROLA<br>CPT4 84443 THYROID STIMULATING HORMONE |
| **5** (2a) | **Denominator Statement:** Adult patients who started amiodarone (see the drug list below) at any time during the first 11 months of the measurement year<br><br>**Time Window:** See below<br><br>**Denominator Details** (Definitions, codes with description):<br>- Age >=18 years as of the end of the measurement year<br>- >=1 Rx claim for amiodarone during the first 11 months of the measurement year, in which the earliest Rx claim during the measurement year is considered to be the amiodarone start date<br>- AND no claims for amiodarone during the 180 period prior to the amiodarone start date (considered the "clean period")<br>- AND eligible for Rx services during the 180 day period prior to the amiodarone start date<br>- AND eligible for medical services from amiodarone start date - 60 days to amiodarone start date - 30 days<br><br>Amiodarone (Medispan Drug)<br>Type Code Description |

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

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| | ------- ------- ----------<br>GPI 3540000500 Amiodarone HCl |
| **6**<br><br>(2a, 2d) | **Denominator Exclusions:**<br>No claims with procedure codes for 'Thyroidectomy, total' (see list of procedure codes below) No claims for services in hospital from amiodarone start date - 60 days to amiodarone start date - 30 days)<br><br>**Denominator Exclusion Details** (Definitions, codes with description):<br>Thyroidectomy, total (Procedure)<br>==========<br>Type Code Description<br>CPT4 60240 THYROIDECTOMY TOTAL OR COMPLETE<br>CPT4 60252 THYROIDECT-MALIG; W/LTD NECK DISSEC<br>CPT4 60254 THYROIDECT-MALIG; W/RAD NECK DISSEC<br>CPT4 60260 THYROIDECTOMY-REMOV ALL REMAIN TISS<br>ICD9P 064 COMPLETE THYROIDECTOMY<br>ICD9P 0652 COMPLETE SUBSTERNAL THYROIDECTOMY<br>ICD9P 303 COMPLETE LARYNGECTOMY<br>ICD9P 304 RADICAL LARYNGECTOMY |
| **7**<br><br>(2a, 2h) | **Stratification** Do the measure specifications require the results to be stratified? No<br>► If "other" describe:<br><br>**Identification of stratification variable(s):**<br><br>**Stratification Details** (Definitions, codes with description): |
| **8**<br><br>(2a, 2e) | **Risk Adjustment** Does the measure require risk adjustment to account for differences in patient severity before the onset of care? Yes ► **If yes,** Results stratified by risk category, see Variables<br>► Is there a separate proprietary owner of the risk model? No<br><br>**Identify Risk Adjustment Variables:** Patients who have had a total thyroidectomy<br><br>**Detailed risk model:** attached ☐ **OR** Web page URL: |
| **9**<br><br>(2a) | **Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☒ **OR** Web page URL:<br><br>**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*)<br>Better quality = Higher score ► If "Other", please describe: |
| **10**<br><br>(2a. 4a, 4b) | **Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** procedure, pharmacy claims<br>**Data dictionary/code table** attached ☒ **OR** Web page URL:<br>**Data Quality** (2a) *Check all that apply*<br>☐ Data are captured from an authoritative/accurate source (e.g., lab values from laboratory personnel)<br>☒ Data are coded using recognized data standards<br>☐ Method of capturing data electronically fits the workflow of the authoritative source<br>☐ Data are available in EHRs<br>☒ Data are auditable |
| **11**<br><br>(2a, 4b) | **Data Source and Data Collection Methods** *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply*<br><br>☐ Electronic Health/Medical Record<br>☐ Electronic Clinical Database, Name:<br>☐ Electronic Clinical Registry, Name:<br>☒ Electronic Claims<br>☒ Electronic Pharmacy data<br>☐ Electronic Lab data<br>☐ Paper Medical Record<br>☐ Standardized clinical instrument, Name:<br>☐ Standardized patient survey, Name:<br>☐ Standardized clinician survey, Name:<br>☒ Other, Describe: It is reasonable to allow physicians to submit definitive evidence that a particular |

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| | ☐ Electronic source – other, Describe: 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.<br><br>Instrument/survey attached ☐ **OR** Web page URL: |
| **12**<br>(2a) | **Sampling** *If measure is based on a sample, provide instructions and guidance on sample size.*<br>**Minimum sample size:** 10<br><br>**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**<br>(2a) | **Type of Measure:** Process ► If "Other", please describe:<br><br>► If part of a composite or paired with another measure, please identify composite or paired measure |
| **14**<br>(2a) | **Unit of Measurement/Analysis** (*Who or what is being measured*) *Check all that apply.*<br>☐ Can be measured at all levels<br>☒ Individual clinician (e.g., physician, nurse)<br>☒ Group of clinicians (e.g., facility department/unit, group practice)<br>☐ Facility (e.g., hospital, nursing home)<br>☒ Integrated delivery system<br>☒ Health plan<br>☒ Community/Population<br>☐ Other (*Please describe*): |
| **15**<br>(2a) | **Applicable Care Settings** *Check all that apply*<br>☐ Can be used in all healthcare settings<br>☒ Ambulatory Care (office/clinic)<br>☐ Behavioral Healthcare<br>☒ Community Healthcare<br>☐ Dialysis Facility<br>☐ Emergency Department<br>☐ EMS emergency medical services<br>☒ Health Plan<br>☐ Home Health<br>☐ Hospice<br>☐ Hospital<br>☐ Long term acute care hospital<br>☐ Nursing home/ Skilled Nursing Facility (SNF)<br>☐ Prescription Drug Plan<br>☐ Rehabilitation Facility<br>☐ Substance Use Treatment Program/Center<br>☐ 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**<br>(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)*: 6.1 |
| **17**<br>(1a) | **If not related to NPP goal, identify high impact aspect of healthcare** (select one)<br><br>**Summary of Evidence:**<br><br>**Citations[2] for Evidence:** |

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

**18** (1b)

**Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.*

**Summary of Evidence:**

| numerator | denominator | proportion |
|---|---|---|
| 0 | 27 | 0.00% |
| 55 | 653 | 8.42% |
| 19 | 190 | 10.00% |
| 69 | 628 | 10.99% |
| 21 | 160 | 13.13% |
| 192 | 1,398 | 13.73% |
| 11 | 64 | 17.19% |
| 134 | 697 | 19.23% |
| 1 | 5 | 20.00% |
| 4 | 18 | 22.22% |
| 525 | 2,320 | 22.63% |
| 9 | 35 | 25.71% |
| 38 | 145 | 26.21% |
| 22 | 71 | 30.99% |
| 31 | 93 | 33.33% |
| 45 | 128 | 35.16% |
| 16 | 37 | 43.24% |
| 13 | 30 | 43.33% |

**Citations for Evidence:** RHI client experience

**19** (1b)

**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.*

**Summary of Evidence:** Not applicable

**Citations for evidence:**

**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
☐ Quantitative research studies
☐ Qualitative research studies

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| | ☐ Systematic synthesis of research ☐ Other (*Please describe*):<br>**Overall Grade for Strength of the Evidence**[3] (*Use the USPSTF system, or if different, also describe how it relates to the USPSTF system)*:<br>**Summary of Evidence** (*provide guideline information below*): See below<br><br>**Citations for Evidence:** |
| **21**<br>(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.*<br><br>**Guideline Citation:**<br>Siddoway LA. Amiodarone: guidelines for use and monitoring. Am Fam Physician. 2003;68(11):2189-96.<br>Baskin, HJ, Cobin RH, et al; AACE Thyroid Task Force. American Association of Clinical Endocrinologists Medical Guidelines for Clinical Practice for the Evaluation and Treatment of Hyperthyroidism and Hypothyroidism. Endocrine Practice. 2002;8(6):457-469.<br><br>Hanja KJ and Licata AA. Effects of amiodarone on thyroid function. Ann Intern Med. 1997;126:63–73.<br><br>**Specific guideline recommendation:** Before the initiation of amiodarone therapy, patients should have a baseline TSH measurement, and then they should be monitored at 6-month intervals during treatment.<br><br>**Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)*: No strength of evidence given -- presented as clinical best practice<br><br>**Rationale for using this guideline over others:** |
| **22**<br>(1c) | **Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.*<br>**Summary:**<br><br>**Citations:** |
| **23**<br>(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: |

[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.

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| **25**<br><br>(2b) | **Reliability Testing**<br><br>**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.<br><br>**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.<br><br>**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**<br><br>(2c) | **Validity Testing**<br><br>**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.<br><br>**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.<br><br>**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**<br><br>(2d) | **Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.*<br><br>**Summary of Evidence supporting exclusion(s):** We exclude patients without a thyroid, which may be affected by amiodarone therapy.<br><br>**Citations for Evidence:**<br><br>**Data/sample:**<br><br>**Analytic Method:**<br><br>**Testing Results:** |
| **28** | **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.* |

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| (2e) | **Data/sample:**<br><br>**Analytic Method:**<br><br>**Testing Results:**<br><br>►**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**<br>(2g) | **Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*)<br>**Data/sample:**<br><br>**Analytic Method:**<br><br>**Results:** |
| **30**<br><br>(2f) | **Provide Measure Results from Testing or Current Use** Results from current use<br><br>**Data/sample:**<br>Aggregate results for this measure using a large 2 year enriched claims data base and a large 3 year enriched claims data base (each with >2M members) = 17.1% compliance and 33.4% compliance, respectively. The compliance rate is defined as the percentage of patients who had a TSH baseline measurement at the start of amiodarone therapy<br><br>**Methods to identify statistically significant and practically/meaningfully differences in performance:**<br>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". 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.<br><br>**Results:**<br>numerator denominator proportion<br>---<br>1,205 6,699 17.99% |
| **31**<br><br>(2h) | **Identification of Disparities**<br>►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:** Not applicable<br><br>►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale: |
| | **USABILITY** |
| **32**<br><br>(3) | *Current Use In use* *If in use, how widely used Nationally* ► *If "other," please describe:*<br><br>☒ *Used in a public reporting initiative, name of initiative: Group Insurance Commission of Massachusetts, Clinical Performance Improvement Initiative and Care Focused Purchasing*<br>*Sample report attached* ☐ *OR Web page URL:* |
| **33** | **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential* |

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| (3a) | *users for public reporting and quality improvement*)<br><br>**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.<br><br>**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.<br><br>**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**<br><br>(3b, 3c) | **Relation to other NQF-endorsed™ measures**<br>►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.*<br>*Check all that apply*<br>☐ Have not looked at other NQF measures ☐ Other measure(s) on same topic<br>☐ Other measure(s) for same target population ☒ No similar or related measures<br><br>**Name of similar or related NQF-endorsed™ measure(s):**<br><br>**Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one)<br>►If not fully harmonized, provide rationale:<br><br>**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**<br><br>(4a) | *How are the required data elements generated? Check all that apply*<br>☐ *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)*<br>☐ *Data elements are generated from a patient survey (e.g., CAHPS)*<br>☒ *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)*<br>☐ *Other, Please describe:* |
| **36**<br><br>(4b) | *Electronic Sources All data elements*<br>►*If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:*<br><br>►*Specify the data elements for the electronic health record:* |
| **37**<br><br>(4c) | *Do the specified exclusions require additional data sources beyond what is required for the other specifications? No*<br><br>►*If yes, provide justification:* |
| **38**<br><br>(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.* |

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| | *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.*<br><br>*Did you audit for these potential problems during testing?* *Yes* *If yes, provide results:* *Through feedback from physicians whose performance has been evaluated.* |
| **39**<br>(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.*<br>*Web page URL:* *www.resolutionhealth.com* |
| **41** | **Measure Intellectual Property Agreement Owner Point of Contact**<br>**First Name:** Alan **MI:** **Last Name:** Lefkowitz **Credentials (MD, MPH, etc.):**<br>**Organization:** Resolution Health<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** alefkowitz@resolutionhealth.com **Telephone:** 240-295-5834 ext: |
| **42** | **Measure Submission Point of Contact** **If different than IP Owner Contact**<br>**First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext: |
| **43** | **Measure Developer Point of Contact** **If different than IP Owner Contact**<br>**First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext: |
| **44** | **Measure Steward Point of Contact** **If different than IP Owner Contact**<br>*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.*<br>**First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext: |
| | **ADDITIONAL INFORMATION** |
| **45** | **Workgroup/Expert Panel involved in measure development** Workgroup/panel used<br>►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 |

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| | 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.<br><br>►Provide a list of workgroup/panel members' names and organizations: **Care Focused Purchasing Clinical Advisory Panel**<br>Bobbie Berg -BCBS -IL<br>Dow Briggs - BCBS- AL<br>Joe Calderella - Cigna<br>Carl Cameron - Preferred Care<br>Steven Goldberg – Humana<br>Tom James – Humana<br>Don Liss – Aetna<br>Catherine MacLean – WellPoint<br>Zak Ramadan–Jradi – Regence<br>Fred Volkman – Avidyn Health<br>Constance Hwang – Resolution Health<br>Darren Schulte - Resolution Health<br>Earl Steinberg – Resolution Health<br><br>**Massachusetts Group Insurance Commission Physician Advisory Panel**<br>Jim Glauber – Neighborhood Health Plan<br>Lyn Laurenco - Neighborhood Health Plan<br>Anton Dodek - Tufts<br>Barbara Chase - Fallon<br>Jonathan Scott Coblyn – Brigham and Women's Hospital<br>Tom Ebert - Health New England<br>Elaine Wilson - Harvard Pilgrim Health Care<br>Jennifer St. Thomas – Tufts<br>Jennifer Lavigne – Fallon<br>Michael O'Shea - Baycare Health<br>Neil Minkoff - Harvard Pilgrim Health Care<br>Paul Mendis- Neighborhood Health Plan<br>Bob Jordan - Neighborhood Health Plan<br>Bob Sorrenti – Unicare<br>Constance Williams – Unicare<br>Laura Syron - Neighborhood Health Plan<br>Susan Tiffany – Unicare<br>Constance Hwang – Resolution Health<br>Darren Schulte - Resolution Health<br>Earl Steinberg – Resolution Health<br>David Gregg – Mercer<br>Russ Robinson - Mercer |
| **46** | *Measure Developer/Steward Updates and Ongoing Maintenance*<br>*Year the measure was first released: 2006*<br>*Month and Year of most recent revision: October 2008*<br>*What is the frequency for review/update of this measure? Annual Review*<br>*When is the next scheduled review/update for this measure? Summer 2009* |
| **47** | **Copyright statement/disclaimers:**<br>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** |

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| | **provided.** ☒ |
| **50** | **Date of Submission** (*MM/DD/YY*)**:** 11/20/2008 |

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 |
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| | **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)<br>*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?<br>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?<br>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

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| | (for NQF staff use) **NQF Review #:** EC-051-08 **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)*: 10/31/08 |
| **2** | **Title of Measure:** Warfarin_PT/ INR Test |
| **3** | **Brief description of measure** [1]**:** This measure identifies the percentage of patients taking warfarin during the measurement year who had at least one PT/INR test within 30 days after the first warfarin prescription in the measurement year |
| **4**<br>(2a) | **Numerator Statement:** Patients in the denominator who had a PT/INR test within 30 days after the first warfarin claim during the measurement year<br><br>**Time Window:** See below<br><br>**Numerator Details** (Definitions, codes with description): - >=1 claim for 'Prothrombin Time' test during 30 days after the latest warfarin claim during the measurement year<br><br>Prothrombin Time (Procedure)<br>Type Code Description<br>CPT4 85610 PROTHROMBIN TIME;<br>CPT4 85611 PT TIME; SUBST PLASMA FRACTIONS EA<br>CPT4 99363 ANTICOAG MGMT, INIT<br>CPT4 99364 ANTICOAG MGMT, SUBSEQ<br>HCPCS G0248 DEMONSTRATE USE HOME INR MONITOR<br>HCPCS G0249 PRVS TST MATL&EQUIP HM INR MON;Q WK<br>HCPCS G0250 PHYS REV INTEPR HOME INR MON; Q WK |
| **5**<br>(2a) | **Denominator Statement:** Patients who are taking warfarin during the measurement year<br><br>**Time Window:** See below<br><br>**Denominator Details** (Definitions, codes with description):<br>- Age >=18 years as of the end of the measurement year<br>- AND have at least 1 Rx claim for warfarin between 31 to 365 days prior to the end of the measurement year (save the earliest Rx claim as the warfarin start date)<br>- AND >=1 Rx claim for warfarin during the 30 days following the warfarin start date<br>- AND eligible for medical services from warfarin start date to warfarin start date + 30 days<br><br>Warfarin (Medispan Drug)<br>Type GPI Code Description<br>GPI 83200030202102 Warfarin Sodium For Inj 5 MG<br>GPI 83200030202900 Warfarin Sodium Powder<br>GPI 83200030200303 Warfarin Sodium Tab 1 MG<br>GPI 83200030200325 Warfarin Sodium Tab 10 MG |

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

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| | GPI 83200030200305 Warfarin Sodium Tab 2 MG<br>GPI 83200030200310 Warfarin Sodium Tab 2.5 MG<br>GPI 83200030200311 Warfarin Sodium Tab 3 MG<br>GPI 83200030200313 Warfarin Sodium Tab 4 MG<br>GPI 83200030200315 Warfarin Sodium Tab 5 MG<br>GPI 83200030200317 Warfarin Sodium Tab 6 MG<br>GPI 83200030200320 Warfarin Sodium Tab 7.5 MG |
| **6**<br>(2a, 2d) | **Denominator Exclusions:**<br>Claims from the hospital or ER from the warfarin start date to warfarin start date + 30 days<br><br>**Denominator Exclusion Details** (Definitions, codes with description): See above |
| **7**<br>(2a, 2h) | **Stratification** Do the measure specifications require the results to be stratified? No<br>► If "other" describe:<br><br>**Identification of stratification variable(s):**<br><br>**Stratification Details** (Definitions, codes with description): |
| **8**<br>(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)<br>► Is there a separate proprietary owner of the risk model? (select one)<br><br>**Identify Risk Adjustment Variables:**<br><br>**Detailed risk model:** attached ☐ **OR** Web page URL: |
| **9**<br>(2a) | **Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☐ **OR** Web page URL:<br><br>**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*)<br>Better quality = Higher score ► If "Other", please describe: |
| **10**<br>(2a. 4a, 4b) | **Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** procedure, pharmacy claims<br>**Data dictionary/code table** attached ☒ **OR** Web page URL:<br>**Data Quality** (2a) *Check all that apply*<br>☐ Data are captured from an authoritative/accurate source (e.g., lab values from laboratory personnel)<br>☒ Data are coded using recognized data standards<br>☐ Method of capturing data electronically fits the workflow of the authoritative source<br>☐ Data are available in EHRs<br>☒ Data are auditable |
| **11**<br>(2a, 4b) | **Data Source and Data Collection Methods** *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply*<br><br>☐ Electronic Health/Medical Record<br>☐ Electronic Clinical Database, Name:<br>☐ Electronic Clinical Registry, Name:<br>☒ Electronic Claims<br>☒ Electronic Pharmacy data<br>☐ Electronic Lab data<br>☐ Electronic source – other, Describe:<br><br>☐ Paper Medical Record<br>☐ Standardized clinical instrument, Name:<br>☐ Standardized patient survey, Name:<br>☐ Standardized clinician survey, Name:<br>☒ 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.<br><br>Instrument/survey attached ☐ **OR** Web page URL: |

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| **12**<br>(2a) | **Sampling** *If measure is based on a sample, provide instructions and guidance on sample size.*<br>**Minimum sample size:** 10<br><br>**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**<br><br>(2a) | **Type of Measure:** Process ► If "Other", please describe:<br><br>► If part of a composite or paired with another measure, please identify composite or paired measure |
| **14**<br>(2a) | **Unit of Measurement/Analysis** (*Who or what is being measured*) *Check all that apply.*<br>☐ Can be measured at all levels<br>☒ Individual clinician (e.g., physician, nurse)<br>☒ Group of clinicians (e.g., facility department/unit, group practice)<br>☐ Facility (e.g., hospital, nursing home)<br>☒ Integrated delivery system<br>☒ Health plan<br>☒ Community/Population<br>☐ Other (*Please describe*): |
| **15**<br>(2a) | **Applicable Care Settings** *Check all that apply*<br>☐ Can be used in all healthcare settings<br>☒ Ambulatory Care (office/clinic)<br>☐ Behavioral Healthcare<br>☒ Community Healthcare<br>☐ Dialysis Facility<br>☐ Emergency Department<br>☐ EMS emergency medical services<br>☒ Health Plan<br>☐ Home Health<br>☐ Hospice<br>☐ Hospital<br>☐ Long term acute care hospital<br>☐ Nursing home/ Skilled Nursing Facility (SNF)<br>☐ Prescription Drug Plan<br>☐ Rehabilitation Facility<br>☐ Substance Use Treatment Program/Center<br>☐ 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**<br>(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)*: 5.3, 5.4, 6.1 |
| **17**<br><br>(1a) | **If not related to NPP goal, identify high impact aspect of healthcare** (select one)<br><br>**Summary of Evidence:**<br><br>**Citations[2] for Evidence:** |
| **18**<br><br>(1b) | **Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.*<br>**Summary of Evidence:**<br>Numerator denominator proportion<br>---<br>28 354 7.91%<br>285 1,148 24.83%<br>1,799 5,532 32.52% |

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

| | | | |
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| | 1,291 | 3,544 | 36.43% |
| | 4,648 | 10,777 | 43.13% |
| | 45 | 98 | 45.92% |
| | 172 | 333 | 51.65% |
| | 8,075 | 14,364 | 56.22% |
| | 484 | 854 | 56.67% |
| | 3,701 | 6,519 | 56.77% |
| | 234 | 390 | 60.00% |
| | 1,092 | 1,570 | 69.55% |
| | 316 | 396 | 79.80% |
| | 76 | 94 | 80.85% |
| | 521 | 644 | 80.90% |
| | 1,328 | 1,599 | 83.05% |
| | 971 | 1,125 | 86.31% |
| | 453 | 512 | 88.48% |

**Citations for Evidence:** RHI client experience

**19** (1b)

**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.*

**Summary of Evidence:** Not applicable

**Citations for evidence:**

**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*

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| ☒ 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)*: See below

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

**Citations for Evidence:** See question #21 below

[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

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| **21**<br>(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.*<br><br>**Guideline Citation:** Hirsch J, Fuster V, Ansell J, and Halperin JL. American Heart Association/American College of Cardiology Foundation Guide to Warfarin Therapy. Circulation. 2003;107:1692-1711.<br><br>**Specific guideline recommendation:** The INR is usually checked daily until the therapeutic range has been reached and sustained for 2 consecutive days, then 2 or 3 times weekly for 1 to 2 weeks, then less often, according to the stability of the results. Once the INR becomes stable, the frequency of testing can be reduced to intervals as long as 4 weeks.<br><br>**Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)***:** No strength of evidence rating provided; guideline recommendation was presented as a clinical best practice<br><br>**Rationale for using this guideline over others:** |
| **22**<br>(1c) | **Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.*<br>**Summary:**<br><br>**Citations:** |
| **23**<br>(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**<br><br>(2b) | **Reliability Testing**<br><br>**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.<br><br>**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 |

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.

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| | 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.<br><br>**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**<br><br>(2c) | **Validity Testing**<br><br>**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.<br><br>**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.<br><br>**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**<br><br>(2d) | **Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.*<br><br>**Summary of Evidence supporting exclusion(s):** Exclude members who have been in the hospital or ER during the period of time that the recommended test is required because post-adjudicated claims data do not always reflect each test performed in the inpatient setting. We therefore do not want to falsely conclude that a test was not performed when it was, but there was no claim for it in the data.<br><br>**Citations for Evidence:**<br><br>**Data/sample:**<br><br>**Analytic Method:**<br><br>**Testing Results:** |
| **28**<br><br>(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.*<br>**Data/sample:**<br><br>**Analytic Method:**<br><br>**Testing Results:**<br><br>►**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. |

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| **29**<br>(2g) | **Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*)<br>**Data/sample:**<br><br>**Analytic Method:**<br><br>**Results:** |
| **30**<br>(2f) | **Provide Measure Results from Testing or Current Use** Results from current use<br><br>**Data/sample:** Group Insurance Commission (GIC):<br>In 2003, the Massachusetts Group Insurance Commission GIC launched the Clinical Performance Improvement initiative, requiring health plans under contract with the GIC to incorporate provider "tiering"—differential payments based on value—into their GIC product. For this initiative, RHI evaluates physician performance on a set of quality measures using administrative claims data from approximately 2.2 million health plan members.<br><br>Care Focused Purchasing (CFP)<br>Care Focused Purchasing, Inc. (CFP) is the largest private or public clinical performance measurement initiative in the nation, representing a coalition of major insurance carriers and more than 50 national self-insured employers. Since CFP's incorporation in 2005, RHI has analyzed medical and pharmacy claims data to assess the quality of care provided by physicians to 29 million CFP employees and members.<br><br>**Methods to identify statistically significant and practically/meaningfully differences in performance:**<br>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.<br><br>**Results:** Pooled results:<br><br>numerator denominator proportion<br>---<br>25,519 49,853 51.19% |
| **31**<br>(2h) | **Identification of Disparities**<br>►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:**<br><br>►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale: |
| | **USABILITY** |
| **32**<br>(3) | **Current Use** In use **If in use, how widely used** Nationally ► If "other," please describe:<br><br>☒ Used in a public reporting initiative, name of initiative: Group Insurance of Massachusetts Clinical Performance Improvement Initiative and Care Focused Purchasing<br>Sample report attached ☐ **OR** Web page URL: |
| **33**<br>(3a) | **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) |

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| | **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.<br><br>**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.<br><br>**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**<br><br>(3b, 3c) | **Relation to other NQF-endorsed™ measures**<br>►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.*<br>*Check all that apply*<br>☐ Have not looked at other NQF measures ☐ Other measure(s) on same topic<br>☐ Other measure(s) for same target population ☒ No similar or related measures<br><br>**Name of similar or related NQF-endorsed™ measure(s):**<br><br>**Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one)<br>►If not fully harmonized, provide rationale:<br><br>**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**<br><br>(4a) | **How are the required data elements generated?** *Check all that apply*<br>☐ 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)<br>☐ Data elements are generated from a patient survey (e.g., CAHPS)<br>☒ 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)<br>☐ Other, Please describe: |
| **36**<br><br>(4b) | **Electronic Sources** All data elements<br>►**If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:**<br><br>►**Specify the data elements for the electronic health record:** |
| **37**<br><br>(4c) | **Do the specified exclusions require additional data sources beyond what is required for the other specifications?** No<br><br>►**If yes, provide justification:** |
| **38**<br><br>(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.<br><br>**Describe how could these potential problems be audited:** Potential data errors of omission or |

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| | 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.<br><br>**Did you audit for these potential problems during testing?** Yes **If yes, provide results:** Through feedback from physicians whose performance has been evaluated. |
| **39**<br>(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.*<br>**Web page URL:** *www.resolutionhealth.com* |
| **41** | **Measure Intellectual Property Agreement Owner Point of Contact**<br>**First Name:** Alan **MI:** **Last Name:** Lefkowitz **Credentials (MD, MPH, etc.):**<br>**Organization:** Resolution Health<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** alefkowitz@resolutionhealth.com **Telephone:** 240-295-5834 ext: |
| **42** | **Measure Submission Point of Contact** **If different than IP Owner Contact**<br>**First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext: |
| **43** | **Measure Developer Point of Contact** **If different than IP Owner Contact**<br>**First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext: |
| **44** | **Measure Steward Point of Contact** **If different than IP Owner Contact**<br>*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.*<br>**First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext: |
| | **ADDITIONAL INFORMATION** |
| **45** | **Workgroup/Expert Panel involved in measure development** Workgroup/panel used<br>►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 |

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| | basis.<br>►Provide a list of workgroup/panel members' names and organizations:<br>Care Focused Purchasing Clinical Advisory Panel<br>Bobbie Berg -BCBS -IL<br>Dow Briggs - BCBS- AL<br>Joe Calderella - Cigna<br>Carl Cameron - Preferred Care<br>Steven Goldberg – Humana<br>Tom James – Humana<br>Don Liss – Aetna<br>Catherine MacLean – WellPoint<br>Zak Ramadan–Jradi – Regence<br>Fred Volkman – Avidyn Health<br>Constance Hwang – Resolution Health<br>Darren Schulte - Resolution Health<br>Earl Steinberg – Resolution Health<br><br>Massachusetts Group Insurance Commission Physician Advisory Panel<br>Jim Glauber – Neighborhood Health Plan<br>Lyn Laurenco - Neighborhood Health Plan<br>Anton Dodek - Tufts<br>Barbara Chase - Fallon<br>Jonathan Scott Coblyn – Brigham and Women's Hospital<br>Tom Ebert - Health New England<br>Elaine Wilson - Harvard Pilgrim Health Care<br>Jennifer St. Thomas – Tufts<br>Jennifer Lavigne – Fallon<br>Michael O'Shea - Baycare Health<br>Neil Minkoff - Harvard Pilgrim Health Care<br>Paul Mendis- Neighborhood Health Plan<br>Bob Jordan - Neighborhood Health Plan<br>Bob Sorrenti – Unicare<br>Constance Williams – Unicare<br>Laura Syron - Neighborhood Health Plan<br>Susan Tiffany – Unicare<br>Constance Hwang – Resolution Health<br>Darren Schulte - Resolution Health<br>Earl Steinberg – Resolution Health<br>David Gregg – Mercer<br>Russ Robinson - Mercer |
| **46** | **Measure Developer/Steward Updates and Ongoing Maintenance**<br>Year the measure was first released: 2005<br>Month and Year of most recent revision: October 2008<br>What is the frequency for review/update of this measure? Annual Review<br>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*)**:** 11/20/2008 |

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 |
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| | *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)*<br>*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?*<br>*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

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| | *(for NQF staff use) NQF Review #: EC-076-08 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): 6/19/09* |
| **2** | *Title of Measure: Lithium Annual Lithium Test in ambulatory setting* |
| **3** | **Brief description of measure [1]:** This measure identifies the percentage of patients taking lithium who have had at least one lithium level test after the earliest observed lithium prescription during the measurement year. |
| **4** (2a) | **Numerator Statement:** Patients in the denominator who received a lithium level test after the earliest observed lithium prescription during the measurement year<br><br>**Time Window:** See below<br><br>**Numerator Details** (Definitions, codes with description): >=1 claim for 'lithium level' from the earliest observed lithium prescription to the end of the measurement year<br><br>lithium level (Procedure)<br>==========<br>Type Code Description<br>------- ------- ----------<br>CPT4 80178 LITHIUM |
| **5** (2a) | **Denominator Statement:** Patients who received at least a 292-day supply of lithium during the measurement year<br><br>**Time Window:** See below<br><br>**Denominator Details** (Definitions, codes with description):<br>- Age >=18 years old as of the end of the measurement year<br>- AND continuous use of 'Lithium Rx' (80%) over the last 365 days<br>- AND has member eligibility within the measurement year<br><br>Lithium Rx (Medispan Drug)<br>==========<br>Type GPI Code Description<br>----- ---------- ----------<br>GPI 59500010100103 Lithium Carbonate Cap 150 MG<br>GPI 59500010100105 Lithium Carbonate Cap 300 MG<br>GPI 59500010100110 Lithium Carbonate Cap 600 MG<br>GPI 59500010102900 Lithium Carbonate Powder<br>GPI 59500010100305 Lithium Carbonate Tab 300 MG<br>GPI 59500010100405 Lithium Carbonate Tab CR 300 MG<br>GPI 59500010100410 Lithium Carbonate Tab CR 450 MG<br>GPI 59500010202010 Lithium Citrate Oral Soln 8 mEq/5ML |
| **6** | **Denominator Exclusions:** None |

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

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| (2a, 2d) | **Denominator Exclusion Details** (Definitions, codes with description): |
| **7**<br><br>(2a, 2h) | **Stratification** Do the measure specifications require the results to be stratified? No<br>► If "other" describe:<br><br>**Identification of stratification variable(s):**<br><br>**Stratification Details** (Definitions, codes with description): |
| **8**<br><br>(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)<br>► Is there a separate proprietary owner of the risk model? (select one)<br><br>**Identify Risk Adjustment Variables:**<br><br>**Detailed risk model:** attached ☐ **OR** Web page URL: |
| **9**<br><br>(2a) | **Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☒ **OR** Web page URL:<br><br>**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*)<br>Better quality = Higher score ► If "Other", please describe: |
| **10**<br><br>(2a. 4a, 4b) | **Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** Procedure, pharmacy claims<br>**Data dictionary/code table** attached ☐ **OR** Web page URL:<br>**Data Quality** (2a) *Check all that apply*<br>☐ Data are captured from an authoritative/accurate source (e.g., lab values from laboratory personnel)<br>☒ Data are coded using recognized data standards<br>☐ Method of capturing data electronically fits the workflow of the authoritative source<br>☐ Data are available in EHRs<br>☒ Data are auditable |
| **11**<br><br>(2a, 4b) | **Data Source and Data Collection Methods** *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply*<br>☐ Electronic Health/Medical Record<br>☐ Electronic Clinical Database, Name:<br>☐ Electronic Clinical Registry, Name:<br>☒ Electronic Claims<br>☒ Electronic Pharmacy data<br>☐ Electronic Lab data<br>☐ Electronic source – other, Describe:<br>☐ Paper Medical Record<br>☐ Standardized clinical instrument, Name:<br>☐ Standardized patient survey, Name:<br>☐ Standardized clinician survey, Name:<br>☒ 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.<br><br>Instrument/survey attached ☐ **OR** Web page URL: |
| **12**<br><br>(2a) | **Sampling** *If measure is based on a sample, provide instructions and guidance on sample size.*<br>**Minimum sample size:** 10<br><br>**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 |

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| | assumption that underlies the model and for public "face validity". Alternatively, to satisfy current NCQA standards, a minimum of 30 observations could be required. |
| **13**<br>(2a) | **Type of Measure:** Process ► If "Other", please describe:<br>► If part of a composite or paired with another measure, please identify composite or paired measure |
| **14**<br>(2a) | **Unit of Measurement/Analysis** (*Who or what is being measured*) *Check all that apply.*<br>☐ Can be measured at all levels<br>☒ Individual clinician (e.g., physician, nurse)<br>☒ Group of clinicians (e.g., facility department/unit, group practice)<br>☐ Facility (e.g., hospital, nursing home)<br>☒ Integrated delivery system<br>☒ Health plan<br>☒ Community/Population<br>☐ Other (*Please describe*): |
| **15**<br>(2a) | **Applicable Care Settings** *Check all that apply*<br>☐ Can be used in all healthcare settings<br>☒ Ambulatory Care (office/clinic)<br>☐ Behavioral Healthcare<br>☒ Community Healthcare<br>☐ Dialysis Facility<br>☐ Emergency Department<br>☐ EMS emergency medical services<br>☒ Health Plan<br>☐ Home Health<br>☐ Hospice<br>☐ Hospital<br>☐ Long term acute care hospital<br>☐ Nursing home/ Skilled Nursing Facility (SNF)<br>☐ Prescription Drug Plan<br>☐ Rehabilitation Facility<br>☐ Substance Use Treatment Program/Center<br>☐ 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**<br>(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)*: 6.1 |
| **17**<br>(1a) | **If not related to NPP goal, identify high impact aspect of healthcare** (select one)<br>**Summary of Evidence:**<br>**Citations[2] for Evidence:** |
| **18**<br>(1b) | **Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.*<br>**Summary of Evidence:** Distinct populations in which the measure was used for physician quality profiling:<br>numerator denominator proportion<br>---<br>69 91 75.82%<br>165 203 81.28%<br>226 277 81.59%<br>53 63 84.13%<br>50 59 84.75%<br>8 9 88.89%<br>**Citations for Evidence:** RHI client experience |
| **19**<br>(1b) | **Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.*<br>**Summary of Evidence:** N/A |

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

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| | **Citations for evidence:** |
| **20**<br><br>(1c) | **If measuring an Outcome** Describe relevance to the national health goal/priority, condition, population, and/or care being addressed:<br><br>**If not measuring an outcome, provide evidence supporting this measure topic and grade the strength of the evidence**<br>*Summarize the evidence (including citations to source) supporting the focus of the measure as follows:*<br>• Intermediate outcome – evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit.<br>• Process – evidence that the measured clinical or administrative process leads to improved health/avoidance of harm and<br>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).<br>• 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.<br>• 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.<br>• Access – evidence that an association exists between access to a health service and the outcomes of, or experience with, care.<br>• 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.<br><br>**Type of Evidence** *Check all that apply*<br>☒ Evidence-based guideline ☐ Quantitative research studies<br>☐ Meta-analysis ☐ Qualitative research studies<br>☐ Systematic synthesis of research ☒ Other (*Please describe*): Expert Opinion<br><br>**Overall Grade for Strength of the Evidence**[3] (*Use the USPSTF system, or if different, also describe how it relates to the USPSTF system)*: The American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Bipolar Disorder includes laboratory monitoring guidelines for patients taking lithium. Please see details below.<br>**Summary of Evidence** (*provide guideline information below*): See below.<br><br>**Citations for Evidence:** See below. |
| **21**<br><br>(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.*<br><br>**Guideline Citation:** American Psychiatric Association. Practice guideline for the treatment of patients with bipolar disorder (revision). Am J Psychiatry. 2002 Apr;159(4 Suppl):1-50<br><br>**Specific guideline recommendation:** "Lithium levels should be checked after each dose increase and before the next." "The clinical status of patients receiving lithium needs to be monitored especially closely. The frequency of monitoring depends on the individual patient's clinical situation but generally should be no less than every 6 months for stable patients. The optimal frequency of serum level monitoring in an individual patient depends on the stability of lithium levels over time for that patient and the degree to which the patient can be relied upon to notice and report symptoms." |

[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.

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| | **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)***:** The guideline states: "Laboratory measures and other diagnostic tests are generally recommended on the basis of pathophysiological knowledge and anticipated clinical decisions rather than on empirical evidence of their clinical utility." There is not a strong research base specifically supporting a link between annual lithium level testing and outcomes. Therefore, the rating of evidence would likely be of moderate to low certainty according to USPSTF guidelines.<br><br>**Rationale for using this guideline over others:** The American Psychiatric Association is a recognized medical specialty society engaged in promoting scientifically established principles of treatment for individuals with mental disorders. |
| **22**<br>(1c) | **Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.*<br>**Summary:** N/A<br><br>**Citations:** |
| **23**<br>(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**<br>(2b) | **Reliability Testing**<br><br>**Data/sample:** We have tested this measure on several patient populations, including, in total, more than 2 million people enrolled in 6 different health plans. In addition, we have used analogous computer algorithms to identify patient-specific QI opportunities in health plan members and have sent messages regarding those opportunities to either the member or the member's physician or both.<br><br>**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.<br><br>**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 physicians, 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**<br>(2c) | **Validity Testing**<br><br>**Data/sample:** We have tested this measure on several patient populations, including, in total, more than 2 million people enrolled in 6 different health plans. In addition, we have used analogous computer algorithms to identify patient-specific QI opportunities in health plan members and have sent messages regarding those opportunities to either the member or the member's physician or both. |

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| | **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.<br><br>**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 different health plans. In addition, the fact that hundreds 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**<br><br>(2d) | **Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.*<br><br>**Summary of Evidence supporting exclusion(s):** N/A<br><br>**Citations for Evidence:**<br><br>**Data/sample:**<br><br>**Analytic Method:**<br><br>**Testing Results:** |
| **28**<br><br>(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.*<br>**Data/sample:** N/A<br><br>**Analytic Method:**<br><br>**Testing Results:**<br><br>►**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**<br><br>(2g) | **Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*)<br>**Data/sample:** N/A<br><br>**Analytic Method:**<br><br>**Results:** |
| **30**<br><br>(2f) | **Provide Measure Results from Testing or Current Use** Results from current use<br><br>**Data/sample:** RHI client experience<br><br>**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 |

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| | 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 health plans participating in the Massachusetts Group Insurance Commission Clinical Performance Improvement Initiative in 2008.<br><br>**Results:** Pooled results:<br><br>numerator denominator proportion<br>---<br>571 702 81.34% |
| **31**<br>(2h) | **Identification of Disparities**<br>►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:**<br><br>►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale: |
| | **USABILITY** |
| **32**<br><br>(3) | *Current Use In use If in use, how widely used State ► If "other," please describe:*<br><br>☒ *Used in a public reporting initiative, name of initiative: The GIC CPII project (Group Insurance Commission Clinical Performance Improvement Initiative) in Massachusetts.*<br>*Sample report attached* ☐ *OR Web page URL:* |
| **33**<br><br>(3a) | **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*)<br><br>**Data/sample:** We have tested this measure on several patient populations, including, in total, more than 2 million people enrolled in 6 different health plans.<br><br>**Methods:** The results have been provided to the medical directors of the 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 national employers.<br><br>**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**<br><br>(3b, 3c) | **Relation to other NQF-endorsed™ measures**<br>►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.*<br>*Check all that apply*<br>☐ Have not looked at other NQF measures ☐ Other measure(s) on same topic<br>☐ Other measure(s) for same target population ☒ No similar or related measures<br><br>**Name of similar or related NQF-endorsed™ measure(s):**<br><br>**Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one)<br>►If not fully harmonized, provide rationale:<br><br>**Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** |

| | FEASIBILITY |
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| **35**<br>(4a) | *How are the required data elements generated? Check all that apply*<br>☐ *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)*<br>☐ *Data elements are generated from a patient survey (e.g., CAHPS)*<br>☒ *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)*<br>☐ *Other, Please describe:* |
| **36**<br>(4b) | *Electronic Sources All data elements*<br>►*If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:*<br><br>►*Specify the data elements for the electronic health record:* |
| **37**<br>(4c) | *Do the specified exclusions require additional data sources beyond what is required for the other specifications? No*<br><br>►*If yes, provide justification:* |
| **38**<br>(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.*<br><br>*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.*<br><br>*Did you audit for these potential problems during testing? Yes If yes, provide results: Through feedback from physicians whose performance has been evaluated.* |
| **39**<br>(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: The technical specifications for all of our measures have been reviewed over time by numerous physicians and have been adjusted when feedback has indicated a way to improve the measure. Our experience suggests that the only practical and affordable approach for evaluation of the performance of individual MDs on a large scale is through use of claims data. We have found there to be benefit from determining whether a particular health plan has capitated arrangements with physicians or other types of providers (e.g. labs and radiology facilities) in a particular geographic area and, in those instances, to only include observations if encounter data are available. We routinely require at least 4 months of "claims runout" after the end of a measurement year in order to take account of claim lag.* |
| | **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.*<br>*Web page URL: www.resolutionhealth.com* |
| **41** | **Measure Intellectual Property Agreement Owner Point of Contact**<br>**First Name:** Alan **MI:** **Last Name:** Lefkowitz **Credentials (MD, MPH, etc.):**<br>**Organization:** Resolution Health, Inc.<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** alefkowitz@resolutionhealth.com **Telephone:** 240-295-5834 ext: |

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| 42 | **Measure Submission Point of Contact** **If different than IP Owner Contact**<br>**First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health, Inc.<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext: |
| 43 | **Measure Developer Point of Contact** **If different than IP Owner Contact**<br>**First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health, Inc.<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext: |
| 44 | **Measure Steward Point of Contact** **If different than IP Owner Contact**<br>*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.*<br>**First Name:** Darren **MI:**M **Last Name:**Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health, Inc.<br>**Street Address:** 10490 Little Patuxent Parkway **City:**Columbia **State:**MD **ZIP:**21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext |
| | **ADDITIONAL INFORMATION** |
| 45 | **Workgroup/Expert Panel involved in measure development** Workgroup/panel used<br>►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.<br>►Provide a list of workgroup/panel members' names and organizations:<br>**Care Focused Purchasing Clinical Advisory Panel**<br>Bobbie Berg -BCBS -IL<br>Dow Briggs - BCBS- AL<br>Joe Calderella - Cigna<br>Carl Cameron - Preferred Care<br>Steven Goldberg – Humana<br>Tom James – Humana<br>Don Liss – Aetna<br>Catherine MacLean – WellPoint<br>Zak Ramadan–Jradi – Regence<br>Fred Volkman – Avidyn Health<br>Constance Hwang – Resolution Health<br>Darren Schulte - Resolution Health<br>Earl Steinberg – Resolution Health<br><br>**Massachusetts Group Insurance Commission Physician Advisory Panel**<br>Jim Glauber – Neighborhood Health Plan<br>Lyn Laurenco - Neighborhood Health Plan<br>Anton Dodek - Tufts<br>Barbara Chase - Fallon<br>Jonathan Scott Coblyn – Brigham and Women's Hospital<br>Tom Ebert - Health New England<br>Elaine Wilson - Harvard Pilgrim Health Care |

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| | Jennifer St. Thomas – Tufts<br>Jennifer Lavigne – Fallon<br>Michael O'Shea - Baycare Health<br>Neil Minkoff - Harvard Pilgrim Health Care<br>Paul Mendis- Neighborhood Health Plan<br>Bob Jordan - Neighborhood Health Plan<br>Bob Sorrenti – Unicare<br>Constance Williams – Unicare<br>Laura Syron - Neighborhood Health Plan<br>Susan Tiffany – Unicare<br>Constance Hwang – Resolution Health<br>Darren Schulte - Resolution Health<br>Earl Steinberg – Resolution Health<br>David Gregg – Mercer<br>Russ Robinson - Mercer |
| **46** | *Measure Developer/Steward Updates and Ongoing Maintenance*<br>*Year the measure was first released: 2007*<br>*Month and Year of most recent revision: September, 2008*<br>*What is the frequency for review/update of this measure? Annual*<br>*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*)**:** 11/20/08 |

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 |
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| | *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)*<br>*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?*<br>*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

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| | *(for NQF staff use) NQF Review #: EC-077-08 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): 06/19/09* |
| **2** | *Title of Measure: Lithium Annual Thyroid Test in ambulatory setting* |
| **3** | **Brief description of measure [1]:** This measure identifies the percentage of patients taking lithium who have had at least one thyroid function test after the earliest observed lithium prescription during the measurement year. |
| **4** (2a) | **Numerator Statement:** Patients in the denominator who received a thyroid function test after the earliest observed lithium prescription during the measurement year<br><br>**Time Window:** See below<br><br>**Numerator Details** (Definitions, codes with description): >=1 claim for 'Thyroid Function Tests' from the earliest observed lithium prescription to the end of the measurement year<br><br>Thyroid Function Tests (Procedure)<br>==========<br>Type Code Description<br>------- ------- ----------<br>CPT4 80418 COMBO RAPID PITUITARY EVAL PANEL<br>CPT4 80050 GENERAL HEALTH PANEL<br>CPT4 84479 THYROID HORMONE UPTAKE/BINDNG RATIO<br>CPT4 84443 THYROID STIMULATING HORMONE<br>CPT4 80440 THYROTROP RELEAS HORMON; HYPERPROLA<br>CPT4 80438 THYROTROPIN RELEAS HORMON STIM; 1HR<br>CPT4 80439 THYROTROPIN RELEAS HORMON STIM; 2HR<br>CPT4 84439 THYROXINE; FREE<br>CPT4 84436 THYROXINE; TOTAL<br>CPT4 84481 TRIIODOTHYRONINE T3; FREE<br>CPT4 84480 TRIIODOTHYRONINE T3; TOTAL |
| **5** (2a) | **Denominator Statement:** Patients who received at least a 292-day supply of lithium during the measurement year<br><br>**Time Window:** See below<br><br>**Denominator Details** (Definitions, codes with description):<br>- Age >=18 years old as of the end of the measurement year<br>- AND continuous use of 'Lithium Rx' (80%) over the last 365 days<br>- AND has member eligibility within the measurement year<br>-AND exclude members with prior claims for total thyroidectomy<br><br>Lithium Rx (Medispan Drug)<br>==========<br>Type GPI Code Description<br>----- ---------- ---------- |

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

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| | GPI 59500010100103 Lithium Carbonate Cap 150 MG<br>GPI 59500010100105 Lithium Carbonate Cap 300 MG<br>GPI 59500010100110 Lithium Carbonate Cap 600 MG<br>GPI 59500010102900 Lithium Carbonate Powder<br>GPI 59500010100305 Lithium Carbonate Tab 300 MG<br>GPI 59500010100405 Lithium Carbonate Tab CR 300 MG<br>GPI 59500010100410 Lithium Carbonate Tab CR 450 MG<br>GPI 59500010202010 Lithium Citrate Oral Soln 8 mEq/5ML |
| **6**<br><br>(2a, 2d) | **Denominator Exclusions:** Exclude patients with prior claims for total thyroidectomy<br><br>**Denominator Exclusion Details** (Definitions, codes with description):<br>No claims for 'Thyroidectomy, total' in any prior available claims up to the date of analysis<br><br>Thyroidectomy, total (Procedure)<br>Type Code Description<br>ICD9P 303 COMPLETE LARYNGECTOMY<br>ICD9P 0652 COMPLETE SUBSTERNAL THYROIDECTOMY<br>ICD9P 064 COMPLETE THYROIDECTOMY<br>ICD9P 304 RADICAL LARYNGECTOMY<br>CPT4 60252 THYROIDECT-MALIG; W/LTD NECK DISSEC<br>CPT4 60254 THYROIDECT-MALIG; W/RAD NECK DISSEC<br>CPT4 60240 THYROIDECTOMY TOTAL OR COMPLETE<br>CPT4 60260 THYROIDECTOMY-REMOV ALL REMAIN TISS |
| **7**<br><br>(2a, 2h) | **Stratification** Do the measure specifications require the results to be stratified? No<br>► If "other" describe:<br><br>**Identification of stratification variable(s):**<br><br>**Stratification Details** (Definitions, codes with description): |
| **8**<br><br>(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)<br>► Is there a separate proprietary owner of the risk model? (select one)<br><br>**Identify Risk Adjustment Variables:**<br><br>**Detailed risk model:** attached ☐ **OR** Web page URL: |
| **9**<br><br>(2a) | **Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☒ **OR** Web page URL:<br><br>**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*)<br>Better quality = Higher score ► If "Other", please describe: |
| **10**<br><br>(2a. 4a, 4b) | **Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** Procedure, pharmacy claims<br>**Data dictionary/code table** attached ☐ **OR** Web page URL:<br>**Data Quality** (2a) *Check all that apply*<br>☐ Data are captured from an authoritative/accurate source (e.g., lab values from laboratory personnel)<br>☒ Data are coded using recognized data standards<br>☐ Method of capturing data electronically fits the workflow of the authoritative source<br>☐ Data are available in EHRs<br>☒ Data are auditable |
| **11** | **Data Source and Data Collection Methods** *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply* |

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| (2a, 4b) | ☐ Electronic Health/Medical Record<br>☐ Electronic Clinical Database, Name:<br>☐ Electronic Clinical Registry, Name:<br>☒ Electronic Claims<br>☒ Electronic Pharmacy data<br>☐ Electronic Lab data<br>☐ Electronic source – other, Describe:<br><br>☐ Paper Medical Record<br>☐ Standardized clinical instrument, Name:<br>☐ Standardized patient survey, Name:<br>☐ Standardized clinician survey, Name:<br>☒ 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.<br><br>Instrument/survey attached ☐ **OR** Web page URL: |
| **12**<br>(2a) | **Sampling** *If measure is based on a sample, provide instructions and guidance on sample size.*<br>**Minimum sample size:** 10<br><br>**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 assumption that underlies the model and for public "face validity". Alternatively, to satisfy current NCQA standards, a minimum of 30 observations could be required. |
| **13**<br>(2a) | **Type of Measure:** Process ► If "Other", please describe:<br><br>► If part of a composite or paired with another measure, please identify composite or paired measure |
| **14**<br>(2a) | **Unit of Measurement/Analysis** (*Who or what is being measured*) *Check all that apply.*<br>☐ Can be measured at all levels<br>☒ Individual clinician (e.g., physician, nurse)<br>☒ Group of clinicians (e.g., facility department/unit, group practice)<br>☐ Facility (e.g., hospital, nursing home)<br>☒ Integrated delivery system<br>☒ Health plan<br>☒ Community/Population<br>☐ Other (*Please describe*): |
| **15**<br>(2a) | **Applicable Care Settings** *Check all that apply*<br>☐ Can be used in all healthcare settings<br>☒ Ambulatory Care (office/clinic)<br>☐ Behavioral Healthcare<br>☒ Community Healthcare<br>☐ Dialysis Facility<br>☐ Emergency Department<br>☐ EMS emergency medical services<br>☒ Health Plan<br>☐ Home Health<br>☐ Hospice<br>☐ Hospital<br>☐ Long term acute care hospital<br>☐ Nursing home/ Skilled Nursing Facility (SNF)<br>☐ Prescription Drug Plan<br>☐ Rehabilitation Facility<br>☐ Substance Use Treatment Program/Center<br>☐ 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**<br>(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)*: 6.1 |
| **17** | **If not related to NPP goal, identify high impact aspect of healthcare** (select one) |

(1a) **Summary of Evidence:**

**Citations[2] for Evidence:**

**18** **Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.*

(1b) **Summary of Evidence:**

Distinct populations in which the measure was used for physician quality profiling:

| numerator | denominator | proportion |
|---|---|---|
| 65 | 90 | 72.22% |
| 209 | 276 | 75.72% |
| 7 | 9 | 77.78% |
| 160 | 203 | 78.82% |
| 47 | 59 | 79.66% |
| 56 | 63 | 88.89% |

**Citations for Evidence:** RHI client experience

**19** **Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.*

(1b) **Summary of Evidence:** N/A

**Citations for evidence:**

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

(1c)

**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*): Expert Opinion

**Overall Grade for Strength of the Evidence[3]** (*Use the USPSTF system, or if different, also describe how it relates to the USPSTF system)*: The American Psychiatric Association (APA) Practice Guideline for the

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

[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

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| | Treatment of Patients with Bipolar Disorder includes laboratory monitoring guidelines for patients taking lithium. Please see details below.<br>**Summary of Evidence** (*provide guideline information below*)**:** See below.<br><br>**Citations for Evidence:** See below. |
| **21**<br><br>(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.*<br><br>**Guideline Citation:** American Psychiatric Association. Practice guideline for the treatment of patients with bipolar disorder (revision). Am J Psychiatry. 2002 Apr;159(4 Suppl):1-50<br><br>**Specific guideline recommendation:** "The decision to recommend a test is based on the probability of detecting a finding that would alter treatment as well as the expected benefit of such alterations in treatment. Recommended tests fall into three categories: 1) baseline measures to facilitate subsequent interpretation of laboratory tests (e.g., ECG, CBC); 2) tests to determine conditions requiring different or additional treatments (e.g., pregnancy, thyroid-stimulating hormone level); and 3) tests to determine conditions requiring alteration of the standard dosage regimen of lithium (e.g., creatinine level)."<br><br>**Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)***:** The guideline states: "Laboratory measures and other diagnostic tests are generally recommended on the basis of pathophysiological knowledge and anticipated clinical decisions rather than on empirical evidence of their clinical utility." Although the guidelines report that hypothyroidism occurs in 5%-35% of patients treated with lithium and imply that testing would have expected benefit, there is not a strong research base specifically supporting a link between testing and outcomes. Therefore, the rating of evidence would likely be of moderate certainty according to USPSTF guidelines.<br><br>**Rationale for using this guideline over others:** The American Psychiatric Association is a recognized medical specialty society engaged in promoting scientifically established principles of treatment for individuals with mental disorders. |
| **22**<br><br>(1c) | **Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations*.<br>**Summary:** N/A<br><br>**Citations:** |
| **23**<br>(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.** |

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.

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| **24** | **Supplemental Testing Information:** attached ☐ **OR** Web page URL: |
| **25**<br><br>(2b) | **Reliability Testing**<br><br>**Data/sample:** We have tested this measure on several patient populations, including, in total, more than 2 million people enrolled in 6 different health plans. In addition, we have used analogous computer algorithms to identify patient-specific QI opportunities in health plan members and have sent messages regarding those opportunities to either the member or the member's physician or both.<br><br>**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.<br><br>**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 physicians, 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**<br><br>(2c) | **Validity Testing**<br><br>**Data/sample:** We have tested this measure on several patient populations, including, in total, more than 2 million people enrolled in 6 different health plans. In addition, we have used analogous computer algorithms to identify patient-specific QI opportunities in health plan members and have sent messages regarding those opportunities to either the member or the member's physician or both.<br><br>**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.<br><br>**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 different health plans. In addition, the fact that hundreds 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**<br><br>(2d) | **Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.*<br><br>**Summary of Evidence supporting exclusion(s):** Patients with a history of total thyroidectomy are excluded since assessment of their thyroid function would not be indicated.<br><br>**Citations for Evidence:** N/A<br><br>**Data/sample:**<br><br>**Analytic Method:**<br><br>**Testing Results:** |
| **28**<br><br>(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.*<br>**Data/sample:** N/A |

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| | **Analytic Method:**<br><br>**Testing Results:**<br><br>►**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**<br>(2g) | **Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*)<br>**Data/sample:** N/A<br><br>**Analytic Method:**<br><br>**Results:** |
| **30**<br><br>(2f) | **Provide Measure Results from Testing or Current Use** Results from current use<br><br>**Data/sample:** RHI client experience<br><br>**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 health plans participating in the Massachusetts Group Insurance Commission Clinical Performance Improvement Initiative in 2008.<br><br>**Results:** Pooled results:<br><br>numerator denominator proportion<br>---<br>544 700 77.71% |
| **31**<br>(2h) | **Identification of Disparities**<br>►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:**<br><br>►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale: |
| | **USABILITY** |
| **32**<br><br>(3) | *Current Use In use  If in use, how widely used State ► If "other," please describe:*<br><br>☒ *Used in a public reporting initiative, name of initiative: The GIC CPII project (Group Insurance Commission Clinical Performance Improvement Initiative) in Massachusetts.*<br>*Sample report attached* ☐ *OR Web page URL:* |
| **33**<br><br>(3a) | **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*)<br><br>**Data/sample:** We have tested this measure on several patient populations, including, in total, more than 2 |

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| | million people enrolled in 6 different health plans.<br><br>**Methods:** The results have been provided to the medical directors of the 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 national employers.<br><br>**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**<br><br>(3b, 3c) | **Relation to other NQF-endorsed™ measures**<br>►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.*<br>*Check all that apply*<br>☐ Have not looked at other NQF measures ☐ Other measure(s) on same topic<br>☐ Other measure(s) for same target population ☒ No similar or related measures<br><br>**Name of similar or related NQF-endorsed™ measure(s):**<br><br>**Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one)<br>►If not fully harmonized, provide rationale:<br><br>**Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** |
| | **FEASIBILITY** |
| **35**<br><br>(4a) | *How are the required data elements generated? Check all that apply*<br>☐ *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)*<br>☐ *Data elements are generated from a patient survey (e.g., CAHPS)*<br>☒ *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)*<br>☐ *Other, Please describe:* |
| **36**<br><br>(4b) | *Electronic Sources All data elements*<br>►*If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:*<br><br>►*Specify the data elements for the electronic health record:* |
| **37**<br><br>(4c) | *Do the specified exclusions require additional data sources beyond what is required for the other specifications? No*<br><br>►*If yes, provide justification:* |
| **38**<br><br>(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.*<br><br>*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.* |

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| | *However, as mentioned above, each of these alternative sources of information also are susceptible to error and thus are not true gold standards.*<br><br>*Did you audit for these potential problems during testing? Yes If yes, provide results: Through feedback from physicians whose performance has been evaluated.* |
| **39**<br><br>(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: The technical specifications for all of our measures have been reviewed over time by numerous physicians and have been adjusted when feedback has indicated a way to improve the measure. Our experience suggests that the only practical and affordable approach for evaluation of the performance of individual MDs on a large scale is through use of claims data. We have found there to be benefit from determining whether a particular health plan has capitated arrangements with physicians or other types of providers (e.g. labs and radiology facilities) in a particular geographic area and, in those instances, to only include observations if encounter data are available. We routinely require at least 4 months of "claims runout" after the end of a measurement year in order to take account of claim lag.* |
| | **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.*<br>*Web page URL: www.resolutionhealth.com* |
| **41** | **Measure Intellectual Property Agreement Owner Point of Contact**<br>**First Name:** Alan **MI:** **Last Name:** Lefkowitz **Credentials (MD, MPH, etc.):**<br>**Organization:** Resolution Health, Inc.<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** alefkowitz@resolutionhealth.com **Telephone:** 240-295-5834 ext: |
| **42** | **Measure Submission Point of Contact** **If different than IP Owner Contact**<br>**First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health, Inc.<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext: |
| **43** | **Measure Developer Point of Contact** **If different than IP Owner Contact**<br>**First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health, Inc.<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext: |
| **44** | **Measure Steward Point of Contact** **If different than IP Owner Contact**<br>*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.*<br>**First Name:** Darren **MI:**M **Last Name:**Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health, Inc.<br>**Street Address:** 10490 Little Patuxent Parkway **City:**Columbia **State:**MD **ZIP:**21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext |
| | **ADDITIONAL INFORMATION** |
| **45** | **Workgroup/Expert Panel involved in measure development** Workgroup/panel used<br>►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 |

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| | 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.<br>►Provide a list of workgroup/panel members' names and organizations:<br>**Care Focused Purchasing Clinical Advisory Panel**<br>Bobbie Berg -BCBS -IL<br>Dow Briggs - BCBS- AL<br>Joe Calderella - Cigna<br>Carl Cameron - Preferred Care<br>Steven Goldberg – Humana<br>Tom James – Humana<br>Don Liss – Aetna<br>Catherine MacLean – WellPoint<br>Zak Ramadan-Jradi – Regence<br>Fred Volkman – Avidyn Health<br>Constance Hwang – Resolution Health<br>Darren Schulte - Resolution Health<br>Earl Steinberg – Resolution Health<br><br>**Massachusetts Group Insurance Commission Physician Advisory Panel**<br>Jim Glauber – Neighborhood Health Plan<br>Lyn Laurenco - Neighborhood Health Plan<br>Anton Dodek - Tufts<br>Barbara Chase - Fallon<br>Jonathan Scott Coblyn – Brigham and Women's Hospital<br>Tom Ebert - Health New England<br>Elaine Wilson - Harvard Pilgrim Health Care<br>Jennifer St. Thomas – Tufts<br>Jennifer Lavigne – Fallon<br>Michael O'Shea - Baycare Health<br>Neil Minkoff - Harvard Pilgrim Health Care<br>Paul Mendis- Neighborhood Health Plan<br>Bob Jordan - Neighborhood Health Plan<br>Bob Sorrenti – Unicare<br>Constance Williams – Unicare<br>Laura Syron - Neighborhood Health Plan<br>Susan Tiffany – Unicare<br>Constance Hwang – Resolution Health<br>Darren Schulte - Resolution Health<br>Earl Steinberg – Resolution Health<br>David Gregg – Mercer<br>Russ Robinson - Mercer |
| **46** | *Measure Developer/Steward Updates and Ongoing Maintenance*<br>*Year the measure was first released: 2007*<br>*Month and Year of most recent revision: September, 2008*<br>*What is the frequency for review/update of this measure? Annual*<br>*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** |

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| | **provided.** ☒ |
| **50** | **Date of Submission** (*MM/DD/YY*)**:** 11/20/08 |

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 |
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| | *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)*<br>*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?*<br>*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

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| | *(for NQF staff use) NQF Review #: EC-119-08 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): 6/19/09* |
| **2** | *Title of Measure: Lithium Annual Creatinine Test in ambulatory setting* |
| **3** | **Brief description of measure [1]:** This measure identifies the percentage of patients taking lithium who have had at least one creatinine test after the earliest observed lithium prescription during the measurement year. |
| **4** (2a) | **Numerator Statement:** Patients in the denominator who received a serum creatinine test after the earliest observed lithium prescription during the measurement year.<br><br>**Time Window:** See below<br><br>**Numerator Details** (Definitions, codes with description): >=1 claim for 'Serum Creatinine' from earliest observed lithium prescription to the end of the measurement year<br><br>Serum Creatinine (Procedure)<br>Type Code Description<br>CPT4 80048 BASIC METABOLIC PANEL<br>CPT4 80053 COMPREHENSIVE METABOLIC PANEL<br>CPT4 82565 CREATININE; BLOOD<br>CPT4 82575 CREATININE; CLEARANCE<br>CPT4 80050 GENERAL HEALTH PANEL<br>CPT4 80048 METABOLIC PANEL TOTAL CA<br>CPT4 80069 RENAL FUNCTION PANEL<br>CPT4 84520 UREA NITROGEN; QUANTITATIVE<br>CPT4 84525 UREA NITROGEN; SEMIQUANTITATIVE |
| **5** (2a) | **Denominator Statement:** Patients who received at least a 292-day supply of lithium during the measurement year<br><br>**Time Window:** See below<br><br>**Denominator Details** (Definitions, codes with description):<br>- Age >=18 years old as of the end of the measurement year<br>- AND continuous use of 'Lithium Rx' (80%) over the last 365 days<br>- AND has member eligibility within the measurement year<br>- AND exclude members with prior claims for end-stage renal disease<br><br>Lithium Rx (Medispan Drug)<br>Type GPI Code Description<br>GPI 59500010100103 Lithium Carbonate Cap 150 MG<br>GPI 59500010100105 Lithium Carbonate Cap 300 MG |

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

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| | GPI 59500010100110 Lithium Carbonate Cap 600 MG<br>GPI 59500010102900 Lithium Carbonate Powder<br>GPI 59500010100305 Lithium Carbonate Tab 300 MG<br>GPI 59500010100405 Lithium Carbonate Tab CR 300 MG<br>GPI 59500010100410 Lithium Carbonate Tab CR 450 MG<br>GPI 59500010202010 Lithium Citrate Oral Soln 8 mEq/5ML |
| **6**<br><br>(2a, 2d) | **Denominator Exclusions:** Exclude patients with prior claims for end-stage renal disease (ESRD)<br><br>**Denominator Exclusion Details** (Definitions, codes with description): No claims for 'ESRD' in any prior available claims up to the date of analysis<br><br>ESRD (Diagnosis)<br>Type Code Description<br>ICD9 5855 CHRONIC KIDNEY DISEASE STAGE V<br>ICD9 V5632 ENCNTR ADEQUACY TEST PERITON DIAL<br>ICD9 V5631 ENCOUNTER ADEQUACY TESTING HEMODIAL<br>ICD9 V560 ENCOUNTER EXTRACORPOREAL DIALYSIS<br>ICD9 V568 ENCOUNTER OTHER DIALYSIS<br>ICD9 5856 END STAGE RENAL DISEASE<br>ICD9 V562 FIT&ADJ PERITON DIALYSIS CATHETER<br>ICD9 V561 FIT&ADJ XTRACORP DIALYSIS CATHETER<br>ICD9 40301 HTN CHR KID DZ MAL KID DZ ST V/ESRD<br>ICD9 40311 HTN CKD BEN W/CKD STAGE V/ESRD<br>ICD9 40391 HTN CKD UNSPEC W/CKD STAGE V/ESRD<br>ICD9 40413 HTN H & CKD BEN HF & CKD ST V/ESRD<br>ICD9 40412 HTN H & CKD BEN W/CKD ST V/ESRD<br>ICD9 40493 HTN H & CKD UNS HF & CKD ST V/ESRD<br>ICD9 40492 HTN H & CKD UNS W/CKD STAGE V/ESRD<br>ICD9 40402 HTN H&CKD MAL W/O HF&CKD ST V/ESRD<br>ICD9 40402 HTN HEART & K DZ MALIG W/CHRON K DZ<br>ICD9 40492 HTN HEART & K DZ UNS W/CHRONIC K DZ<br>ICD9 40403 HTN HRT & CKD MAL HF&CKD ST V/ESRD<br>ICD9 40413 HTN HRT & K DZ BEN W/HF & CKD<br>ICD9 40412 HTN HRT & K DZ BENIGN W/CHRON K DZ<br>ICD9 40403 HTN HRT & K DZ MALIG W/HF & CHRN K<br>ICD9 40493 HTN HRT & K DZ UNS W/HF & CHRN K DZ<br>ICD9 40311 HTN KIDNEY DZ BEN W/CHRON KID DZ<br>ICD9 40301 HTN KIDNEY DZ MALIG W/CHRON KID DZ<br>ICD9 40391 HTN KIDNEY DZ UNS W/ CKD<br>ICD9 V451 RENAL DIALYSIS STATUS |
| **7**<br><br>(2a, 2h) | **Stratification** Do the measure specifications require the results to be stratified? No<br>► If "other" describe:<br><br>**Identification of stratification variable(s):**<br><br>**Stratification Details** (Definitions, codes with description): |
| **8**<br><br>(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)<br>► Is there a separate proprietary owner of the risk model? (select one)<br><br>**Identify Risk Adjustment Variables:**<br><br>**Detailed risk model:** attached ☐ **OR** Web page URL: |
| **9** | **Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☒ **OR** Web page URL: |

(2a) **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** **Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** Diagnosis, procedure, pharmacy claims

(2a. 4a, 4b) **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** **Data Source and Data Collection Methods** *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply*

(2a, 4b)
☐ 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** **Sampling** *If measure is based on a sample, provide instructions and guidance on sample size.*
**Minimum sample size:** 10

(2a)
**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 assumption that underlies the model and for public "face validity". Alternatively, to satisfy current NCQA standards, a minimum of 30 observations could be required.

**13** **Type of Measure:** Process ► If "Other", please describe:

(2a) ► If part of a composite or paired with another measure, please identify composite or paired measure

**14** **Unit of Measurement/Analysis** (*Who or what is being measured*) *Check all that apply.*

(2a)
☐ 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** **Applicable Care Settings** *Check all that apply*

(2a)
☐ Can be used in all healthcare settings
☒ Ambulatory Care (office/clinic)
☐ Hospice
☐ Hospital

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| | ☐ Behavioral Healthcare<br>☒ Community Healthcare<br>☐ Dialysis Facility<br>☐ Emergency Department<br>☐ EMS emergency medical services<br>☒ Health Plan<br>☐ Home Health<br>☐ Long term acute care hospital<br>☐ Nursing home/ Skilled Nursing Facility (SNF)<br>☐ Prescription Drug Plan<br>☐ Rehabilitation Facility<br>☐ Substance Use Treatment Program/Center<br>☐ 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**<br>(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)*: 6.1 |
| **17**<br><br>(1a) | **If not related to NPP goal, identify high impact aspect of healthcare** (select one)<br><br>**Summary of Evidence:**<br><br>**Citations[2] for Evidence:** |
| **18**<br><br>(1b) | **Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.*<br>**Summary of Evidence:**<br>Distinct populations in which the measure was used for physician quality profiling:<br><br>numerator denominator proportion<br>---<br>70 91 76.92%<br>223 277 80.51%<br>53 62 85.48%<br>174 203 85.71%<br>8 9 88.89%<br>53 58 91.38%<br><br>**Citations for Evidence:** RHI client experience |
| **19**<br><br>(1b) | **Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.*<br>**Summary of Evidence:** N/A<br><br>**Citations for evidence:** |
| **20**<br><br>(1c) | **If measuring an Outcome** Describe relevance to the national health goal/priority, condition, population, and/or care being addressed:<br><br>**If not measuring an outcome, provide evidence supporting this measure topic and grade the strength of the evidence**<br>*Summarize the evidence (including citations to source) supporting the focus of the measure as follows:*<br>• Intermediate outcome – evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit.<br>• Process – evidence that the measured clinical or administrative process leads to improved health/avoidance of harm and<br>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).<br>• 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.<br>• Patient experience – evidence that an association exists between the measure of patient experience of |

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

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| | health care and the outcomes, values and preferences of individuals/ the public.<br>• Access – evidence that an association exists between access to a health service and the outcomes of, or experience with, care.<br>• 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.<br><br>**Type of Evidence** *Check all that apply*<br>☐ Evidence-based guideline ☐ Quantitative research studies<br>☐ Meta-analysis ☒ Qualitative research studies<br>☐ Systematic synthesis of research ☒ Other (*Please describe*): Expert Opinion<br><br>**Overall Grade for Strength of the Evidence**[3] (*Use the USPSTF system, or if different, also describe how it relates to the USPSTF system)***:** The American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Bipolar Disorder includes laboratory monitoring guidelines for patients taking lithium. Please see details below.<br>**Summary of Evidence** (*provide guideline information below*)**:** See below.<br><br>**Citations for Evidence:** See below. |
| **21**<br><br>(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.*<br><br>**Guideline Citation:** American Psychiatric Association. Practice guideline for the treatment of patients with bipolar disorder (revision). Am J Psychiatry. 2002 Apr;159(4 Suppl):1-50<br><br>**Specific guideline recommendation:** "The decision to recommend a test is based on the probability of detecting a finding that would alter treatment as well as the expected benefit of such alterations in treatment. Recommended tests fall into three categories: 1) baseline measures to facilitate subsequent interpretation of laboratory tests (e.g., ECG, CBC); 2) tests to determine conditions requiring different or additional treatments (e.g., pregnancy, thyroid-stimulating hormone level); and 3) tests to determine conditions requiring alteration of the standard dosage regimen of lithium (e.g., creatinine level)."<br><br>**Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)***:** The guideline states: "Laboratory measures and other diagnostic tests are generally recommended on the basis of pathophysiological knowledge and anticipated clinical decisions rather than on empirical evidence of their clinical utility." However, the guideline also states that there are a number of case reports describing renal insufficiency likely due to lithium and imply that testing is recommended since there is expected benefit. Therefore, the rating of evidence would likely be of moderate certainty according to USPSTF guidelines.<br><br>**Rationale for using this guideline over others:** The American Psychiatric Association is a recognized medical specialty society engaged in promoting scientifically established principles of treatment for individuals with mental disorders. |
| **22**<br><br>(1c) | **Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.*<br>**Summary:** N/A |

[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.

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| | **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:** 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**<br><br>(2b) | **Reliability Testing**<br><br>**Data/sample:** We have tested this measure on several patient populations, including, in total, more than 2 million people enrolled in 6 different health plans. In addition, we have used analogous computer algorithms to identify patient-specific QI opportunities in health plan members and have sent messages regarding those opportunities to either the member or the member's physician or both.<br><br>**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."<br><br>**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 physicians, 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**<br><br>(2c) | **Validity Testing**<br><br>**Data/sample:** We have tested this measure on several patient populations, including, in total, more than 2 million people enrolled in 6 different health plans. In addition, we have used analogous computer algorithms to identify patient-specific QI opportunities in health plan members and have sent messages regarding those opportunities to either the member or the member's physician or both.<br><br>**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.<br><br>**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 different health plans. In addition, the fact that hundreds of physicians have received results based on this measure without indicating that they don't believe the measure is valid attests to its validity. |

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| **27**<br>(2d) | **Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.*<br><br>**Summary of Evidence supporting exclusion(s):** Exclusion of members with end-stage renal disease is done since in these patients kidney function has already declined to the point of requiring dialysis or transplant.<br><br>**Citations for Evidence:** N/A<br><br>**Data/sample:**<br><br>**Analytic Method:**<br><br>**Testing Results:** |
| **28**<br>(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.*<br>**Data/sample:** N/A<br><br>**Analytic Method:**<br><br>**Testing Results:**<br><br>►**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**<br>(2g) | **Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*)<br>**Data/sample:** N/A<br><br>**Analytic Method:**<br><br>**Results:** |
| **30**<br>(2f) | **Provide Measure Results from Testing or Current Use** Results from current use<br><br>**Data/sample:** RHI client experience<br><br>**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 health plans participating in the Massachusetts Group Insurance Commission Clinical Performance Improvement Initiative in 2008.<br><br>**Results:** Pooled results:<br><br>numerator denominator proportion<br>---<br>581 700 83.00% |
| **31** | **Identification of Disparities** |

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| (2h) | ►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:**<br><br>►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale: |
| | **USABILITY** |
| **32**<br><br>(3) | *Current Use In use* *If in use, how widely used State* ► *If "other," please describe:*<br><br>☒ *Used in a public reporting initiative, name of initiative: The GIC CPII project (Group Insurance Commission Clinical Performance Improvement Initiative) in Massachusetts.*<br>*Sample report attached* ☐ *OR Web page URL:* |
| **33**<br><br>(3a) | **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*)<br><br>**Data/sample:** We have tested this measure on several patient populations, including, in total, more than 2 million people enrolled in 6 different health plans.<br><br>**Methods:** The results have been provided to the medical directors of the 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 national employers.<br><br>**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**<br><br>(3b, 3c) | **Relation to other NQF-endorsed™ measures**<br>►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.*<br>*Check all that apply*<br>☐ Have not looked at other NQF measures ☐ Other measure(s) on same topic<br>☐ Other measure(s) for same target population ☒ No similar or related measures<br><br>**Name of similar or related NQF-endorsed™ measure(s):**<br><br>**Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one)<br>►If not fully harmonized, provide rationale:<br><br>**Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** |
| | **FEASIBILITY** |
| **35**<br><br>(4a) | *How are the required data elements generated? Check all that apply*<br>☐ *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)*<br>☐ *Data elements are generated from a patient survey (e.g., CAHPS)*<br>☒ *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)*<br>☐ *Other, Please describe:* |
| **36**<br><br>(4b) | *Electronic Sources All data elements*<br>►*If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:* |

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| | ►*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<br><br>►*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.<br><br>*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.<br><br>*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:* The technical specifications for all of our measures have been reviewed over time by numerous physicians and have been adjusted when feedback has indicated a way to improve the measure. Our experience suggests that the only practical and affordable approach for evaluation of the performance of individual MDs on a large scale is through use of claims data. We have found there to be benefit from determining whether a particular health plan has capitated arrangements with physicians or other types of providers (e.g. labs and radiology facilities) in a particular geographic area and, in those instances, to only include observations if encounter data are available. We routinely require at least 4 months of "claims runout" after the end of a measurement year in order to take account of claim lag. |
| | **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.*<br>*Web page URL:* www.resolutionhealth.com |
| **41** | **Measure Intellectual Property Agreement Owner Point of Contact**<br>**First Name:** Alan **MI:** **Last Name:** Lefkowitz **Credentials (MD, MPH, etc.):**<br>**Organization:** Resolution Health, Inc.<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** alefkowitz@resolutionhealth.com **Telephone:** 240-295-5834 ext: |
| **42** | **Measure Submission Point of Contact** **If different than IP Owner Contact**<br>**First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health, Inc.<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext: |
| **43** | **Measure Developer Point of Contact** **If different than IP Owner Contact**<br>**First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health, Inc.<br>**Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext: |
| **44** | **Measure Steward Point of Contact** **If different than IP Owner Contact** |

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| | *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.*<br>**First Name:** Darren **MI:**M **Last Name:**Schulte **Credentials (MD, MPH, etc.):** MD, MPP<br>**Organization:** Resolution Health, Inc.<br>**Street Address:** 10490 Little Patuxent Parkway **City:**Columbia **State:**MD **ZIP:**21044<br>**Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext |
| | **ADDITIONAL INFORMATION** |
| **45** | **Workgroup/Expert Panel involved in measure development** Workgroup/panel used<br>►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.<br>►Provide a list of workgroup/panel members' names and organizations: Care Focused Purchasing Clinical Advisory Panel<br>Bobbie Berg -BCBS -IL<br>Dow Briggs - BCBS- AL<br>Joe Calderella - Cigna<br>Carl Cameron - Preferred Care<br>Steven Goldberg – Humana<br>Tom James – Humana<br>Don Liss – Aetna<br>Catherine MacLean – WellPoint<br>Zak Ramadan–Jradi – Regence<br>Fred Volkman – Avidyn Health<br>Connie Hwang – Resolution Health<br>Darren Schulte - Resolution Health<br><br>Massachusetts Group Insurance Commission Physician Advisory Panel<br>Jim Glauber – Neighborhood Health Plan<br>Lyn Laurenco - Neighborhood Health Plan<br>Anton Dodek - Tufts<br>Barbara Chase - Fallon<br>Jonathan Scott Coblyn – Brigham and Women's Hospital<br>Tom Ebert - Health New England<br>Elaine Wilson - Harvard Pilgrim Health Care<br>Jennifer St. Thomas – Tufts<br>Jennifer Lavigne – Fallon<br>Michael O'Shea - Baycare Health<br>Neil Minkoff - Harvard Pilgrim Health Care<br>Paul Mendis- Neighborhood Health Plan<br>Bob Jordan - Neighborhood Health Plan<br>Bob Sorrenti – Unicare<br>Constance Williams – Unicare<br>Laura Syron - Neighborhood Health Plan<br>Susan Tiffany – Unicare<br>Connie Hwang – Resolution Health<br>Darren Schulte - Resolution Health<br>David Gregg – Mercer |

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| | Russ Robinson - Mercer |
| **46** | *Measure Developer/Steward Updates and Ongoing Maintenance*<br>*Year the measure was first released: 2007*<br>*Month and Year of most recent revision: July, 2007*<br>*What is the frequency for review/update of this measure? Annual*<br>*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*)**:** 11/20/08 |

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 |
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| | *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)*<br>*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

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| | *(for NQF staff use)* NQF Review #: EC-204-08 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:* Warfarin - INR Monitoring |
| **3** | **Brief description of measure [1]:** Percentage of patients taking warfarin with PT/INR monitoring |
| **4** (2a) | **Numerator Statement:** Patients who had PT/INR monitoring<br>**Time Window:** 4 months<br>**Numerator Details** (Definitions, codes with description): see attached |
| **5** (2a) | **Denominator Statement:** Patients with a current refill for warfarin<br>**Time Window:** A current refill is defined 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.<br>**Denominator Details** (Definitions, codes with description): see attached |
| **6** (2a, 2d) | **Denominator Exclusions:**<br>Specific exclusions<br>• Dialysis<br>General exclusions:<br>• Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months;<br>• Patients who have been in a skilled nursing facility in the last 3 months<br>**Denominator Exclusion Details** (Definitions, codes with description): see attached |
| **7** (2a, 2h) | **Stratification** Do the measure specifications require the results to be stratified? No<br>► If "other" describe:<br>**Identification of stratification variable(s):**<br>**Stratification Details** (Definitions, codes with description): |
| **8** | **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) |

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

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

| | IMPORTANCE TO MEASURE AND REPORT |
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| | **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)<br><br>**Summary of Evidence:**<br><br>**Citations[2] for Evidence:** |
| **18** (1b) | **Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.*<br>**Summary of Evidence:** Patients taking warfarin require regular blood tests to ensure that the level of anticoagulation reaches and remains within a defined target range. If the INR is high or low, the patient may not be adhering to the regimen. In general, a missed dose of warfarin is reflected in the INR within about 2 to 5 days after the dose is missed.<br><br>**Citations for Evidence:** American Heart Association/American College of Cardiology Foundation Guide to Warfarin Therapy Circulation. 2003;107:1692-1711. |
| **19** (1b) | **Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.*<br>**Summary of Evidence:**<br><br>**Citations for evidence:** |
| **20** (1c) | **If measuring an Outcome** Describe relevance to the national health goal/priority, condition, population, and/or care being addressed:<br><br>**If not measuring an outcome, provide evidence supporting this measure topic and grade the strength of the evidence**<br>*Summarize the evidence (including citations to source) supporting the focus of the measure as follows:*<br>• Intermediate outcome – evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit.<br>• 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).<br>• 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.<br>• 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.<br>• Access – evidence that an association exists between access to a health service and the outcomes of, or experience with, care.<br>• 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.<br><br>**Type of Evidence** *Check all that apply*<br>☒ Evidence-based guideline ☐ Quantitative research studies<br>☐ Meta-analysis ☐ Qualitative research studies<br>☐ Systematic synthesis of research ☐ Other (*Please describe*):<br><br>**Overall Grade for Strength of the Evidence[3]** (*Use the USPSTF system, or if different, also describe how it* |

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

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| | *relates to the USPSTF system)*: Grade 2C: weak recommendations based on low-quality evidence (Grading system similar to the USPSTF system.)<br>**Summary of Evidence** (*provide guideline information below*): The intensity of anticoagulation therapy should be monitored closely until the patient has reached a stable PT/INR. Once the patient is stabilized on a fixed dose of warfarin, the PT/INR can be monitored on a monthly basis if the patient demonstrates a stable PT/INR on chronic therapy. Determinants of bleeding due to warfarin therapy include intensity of treatment, patient characteristics, concomitant use of drugs that interfere with hemostasis, and the length therapy. The target INR should be established with consideration of these factors. After warfarin treatment is started, the INR response should be monitored frequently until a stable dose-response relationship is obtained; thereafter, the frequency of INR testing is reduced. Once the INR becomes stable, the frequency of testing can be reduced to intervals as long as 4 weeks.<br><br>**Citations for Evidence:** AHA/ACC Scientific Statement: American Heart Association/American College of Cardiology Foundation Guide to Warfarin Therapy Circulation. 2003;107:1692-1711<br><br>Pharmacology and Management of the Vitamin K Antagonists: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition). Chest, 2008, 133(6 Suppl):160S-98S. |
| **21**<br>(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.*<br><br>**Guideline Citation:** Pharmacology and Management of the Vitamin K Antagonists: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition). Chest, 2008, 133(6 Suppl):160S-98S.<br><br>**Specific guideline recommendation:** For patients who are receiving a stable dose of oral anticoagulants, we suggest monitoring at an interval of no longer than every 4 weeks.<br><br>**Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)*: Grade 2C: weak recommendation based on low-quality evidence<br><br>**Rationale for using this guideline over others:** Nationally recognized guideline in antithrombotic and thrombolytic therapy |
| **22**<br>(1c) | **Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.*<br>**Summary:**<br><br>**Citations:** |
| **23**<br>(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:** Patients taking warfarin require regular blood tests to ensure that the level of anticoagulation reaches and remains within a defined target range. |
| | **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** |

[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.

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| | **been tested, it is only potentially eligible for time-limited endorsement.** |
| **24** | **Supplemental Testing Information:** attached ☐ **OR** Web page URL: |
| **25**<br><br>(2b) | **Reliability Testing**<br><br>**Data/sample:**<br><br>**Analytic Method:**<br><br>**Testing Results:** |
| **26**<br><br>(2c) | **Validity Testing**<br><br>**Data/sample:**<br><br>**Analytic Method:**<br><br>**Testing Results:** |
| **27**<br><br>(2d) | **Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.*<br><br>**Summary of Evidence supporting exclusion(s):**<br><br>**Citations for Evidence:**<br><br>**Data/sample:**<br><br>**Analytic Method:**<br><br>**Testing Results:** |
| **28**<br><br>(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.*<br>**Data/sample:**<br><br>**Analytic Method:**<br><br>**Testing Results:**<br><br>►**If outcome or resource use measure not risk adjusted, provide rationale:** |
| **29**<br><br>(2g) | **Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*)<br>**Data/sample:**<br><br>**Analytic Method:**<br><br>**Results:** |
| **30**<br><br>(2f) | **Provide Measure Results from Testing or Current Use** Results from testing<br><br>**Data/sample:** We measured a commercial population of 459,196 members.<br><br>**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 INR monitoring. In addition, where appropriate we analyze patient data collected either from the patient's PHR or during a disease management program.<br><br>**Results:** We found that of the 352 members who satisfied the denominator, 55 were in the numerator, |

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| | indicating a compliance rate of 16%. |
| **31**<br>(2h) | **Identification of Disparities**<br>►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:**<br><br>►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale: |
| | **USABILITY** |
| **32**<br>(3) | *Current Use Testing completed If in use, how widely used Health plan or sytem ► If "other," please describe:*<br><br>☐ *Used in a public reporting initiative, name of initiative:*<br>*Sample report attached* ☐ *OR Web page URL:* |
| **33**<br>(3a) | **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*)<br><br>**Data/sample:** Administrative claims database from health plans, pharmacy data, lab data, patient derived data<br><br>**Methods:** The performance measure is similar in message to a clinical alert that has been operational since 2000. Compliance to the clinical alert is measured using an analysis of subsequent claims, in this case the appearance of claims for INR monitoring. In addition, a feedback tool accompanies every clinical alert message, and includes options indicating agreement or disagreement with the message.<br><br>**Results:** In practice, fewer than 1% of the respondents disagreed with the medical literature, and more than 56% show objective evidence of compliance. |
| **34**<br>(3b, 3c) | **Relation to other NQF-endorsed™ measures**<br>►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.*<br>*Check all that apply*<br>☐ Have not looked at other NQF measures ☐ Other measure(s) on same topic<br>☐ Other measure(s) for same target population ☒ No similar or related measures<br><br>**Name of similar or related NQF-endorsed™ measure(s):**<br><br>**Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one)<br>►If not fully harmonized, provide rationale:<br><br>**Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** |
| | **FEASIBILITY** |
| **35**<br>(4a) | *How are the required data elements generated? Check all that apply*<br>☒ *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)*<br>☐ *Data elements are generated from a patient survey (e.g., CAHPS)*<br>☒ *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)*<br>☒ *Other, Please describe: Data obtained through electronic personal health records and telephonic, nurse-driven disease management programs* |
| **36**<br>(4b) | *Electronic Sources All data elements*<br>►*If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:* |

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| | ►*Specify the data elements for the electronic health record:* *ICD9, CPT, NDC, Loinc codes and patient derived data* |
| **37** (4c) | *Do the specified exclusions require additional data sources beyond what is required for the other specifications?* *No*<br><br>►*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.*<br><br>*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.*<br><br>*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.*<br><br>*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.*<br>*Web page URL:* *www.activehealth.net* |
| **41** | **Measure Intellectual Property Agreement Owner Point of Contact**<br>**First Name:** Madhavi **MI:** **Last Name:** Vemireddy **Credentials (MD, MPH, etc.):** MD<br>**Organization:** ActiveHealth Management<br>**Street Address:** 102 Madison Avenue **City:** New York **State:** NY **ZIP:** 10016<br>**Email:** mvemireddy@activehealth.net **Telephone:** 212-651-8200 ext: |
| **42** | **Measure Submission Point of Contact** **If different than IP Owner Contact**<br>**First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):**<br>**Organization:**<br>**Street Address:** **City:** **State:** **ZIP:**<br>**Email:** **Telephone:** ext: |
| **43** | **Measure Developer Point of Contact** **If different than IP Owner Contact**<br>**First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):**<br>**Organization:**<br>**Street Address:** **City:** **State:** **ZIP:**<br>**Email:** **Telephone:** ext: |

| | |
|---|---|
| **44** | **Measure Steward Point of Contact** **If different than IP Owner Contact**<br>*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.*<br>**First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):**<br>**Organization:**<br>**Street Address:** **City:** **State:** **ZIP:**<br>**Email:** **Telephone:** ext |
| | **ADDITIONAL INFORMATION** |
| **45** | **Workgroup/Expert Panel involved in measure development** No workgroup or panel used<br>►If workgroup used, describe the members' role in measure development:<br>►Provide a list of workgroup/panel members' names and organizations: |
| **46** | *Measure Developer/Steward Updates and Ongoing Maintenance*<br>*Year the measure was first released: 2000*<br>*Month and Year of most recent revision: 2/2009*<br>*What is the frequency for review/update of this measure? Biennially*<br>*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:**
**Warfarin - INR Monitoring**

**DENOMINATOR**

One of the following is correct:

1. Presence of a current refill of WARFARIN (w/o 1mg tabs) 60-day total supply in the past 4 months

2. Presence of patient data confirming a current refill of WARFARIN

**DENOMINATOR EXCLUSIONS**

The following is correct:

1. Presence of at least 1 DIALYSIS ALL (CPT) procedure in the past 4 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 PROTHROMBIN TIME procedure in the past 4 months

b. Presence of patient data confirming at least 1 PDD- INR in the past 4 months

c. Presence of at least 1 INR VALUE Labs Result Value in the past 4 months

d. Presence of at least 1 LONG-TERM ANTICOAGULATION diagnosis in the past 4 months

e. Presence of at least 1 PROTHROMBIN TIME Lab Result Value in the past 4 months

**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.

**PERFORMANCE MEASURE RULE:**
**Levothyroxine - Annual TSH Monitoring**

## DENOMINATOR:

The following is correct:

Presence of at least 360 days supply of LEVOTHYROXINE in the past 15 months

## DENOMINATOR EXCLUSIONS

Presence of at least 1 PANHYPOPITUITARISM (ICD- 9) diagnosis in the past 3 years

## NUMERATOR:

All of the following are correct:

1. Denominator is true
2. One of the following is correct:
    a. Presence of at least 1 THYROID FUNCTION TESTS procedure in the past 12 months
    b. Presence of at least 1 ABNORMAL THYROID FUNCTION TEST diagnosis in the past 12 months
    c. Presence of at least 1 THYROID FUNCTION LOINC result in the past 12 months
    d. Presence of at least 1 TSH (CPT) procedure in the past 12 months
    e. Presence of At Least 1 TSH Labs Result Value In the past 12 Months

**Note:** A 3 month time window has been added to certain timeframes 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.