

Health and Well-Being 2015-2017

TECHNICAL REPORT

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**NATIONAL
QUALITY FORUM**

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Health and Well-Being 2015-2017

TECHNICAL REPORT

Executive Summary

Many people think of medical care when talking about how to improve the health and well-being of individuals and populations. Medical care, however, has a relatively small influence on overall health when compared with behaviors such as smoking, poor diet, physical environmental hazards, such as polluted air and unsafe roadways, and social factors like low educational achievement and poverty.¹ Maintaining and improving the health and well-being of individuals and populations requires a multidisciplinary, multifactorial approach. Social, environmental, economic, and behavioral factors all play a significant role. These and other determinants of health contribute to up to 60 percent of deaths in the United States,² yet less than 5 percent of health expenditures are spent on prevention.³

While this project focused on measure endorsement, the National Quality Forum's (NQF) work in health and well-being extends well beyond measure endorsement, and includes work focused on [reducing disparities in health outcomes](#) and promoting and [coordinating multistakeholder communities to improve local population health](#). For example, to consider how performance measurement could accelerate improvements in population health, NQF commissioned a report to define concepts and identify the challenges and opportunities to align health improvement activities and measurement across the clinical care and government public health systems ([Jacobson and Teutsch, 2012](#)). To be proactive, NQF also has provided guidance on measure evaluation for [population health](#) and [access](#) measures to promote measure development in these areas.

NQF's Health and Well-Being portfolio of measures includes measures for health-related behaviors to promote healthy living; community-level indicators of health and disease; modifiable social, economic, and environmental determinants of health; primary prevention and/or screening; and oral health (see [Appendix B](#)).

Overall, the Health and Well-Being Standing Committee was pleased to see new measures addressing new foci, as well as—for the first time for the health and well-being portfolio—several eMeasures. The Committee expressed significant concern, however, about the lack of progress to consolidate the many influenza vaccination measures into a single harmonized, universal measure across care sectors—a recommendation it made in June 2012.

For this project, the Standing Committee evaluated 12 newly submitted measures and 11 measures undergoing maintenance review against NQF's standard evaluation criteria. Ultimately, 13 measures are endorsed, one measure receives Inactive Endorsement with Reserve Status, three measures are approved for trial use, and six measures are not endorsed.

The 13 measures endorsed are:

- 0032 Cervical Cancer Screening (CCS) (National Committee for Quality Assurance)
- 0038 Childhood Immunization Status (CIS) (National Committee for Quality Assurance)
- 0039 Flu Vaccinations for Adults Ages 18 and Older (National Committee for Quality Assurance)
- 0041 Preventive Care and Screening: Influenza Immunization (PCPI Foundation)

- 0226 Influenza Immunization in the ESRD Population (Facility Level) (Kidney Care Quality Alliance)
- 0279 Bacterial Pneumonia Admission Rate (PQI 11) (Agency for Healthcare Research and Quality) (Please note: Upon recommendation from the Pulmonary and Critical Care Standing Committee, the developer has agreed to change the name to better reflect the measure focus.)
- 0431 Influenza Vaccination Coverage Among Healthcare Personnel (Centers for Disease Control and Prevention)
- 0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay) (Centers for Medicare & Medicaid Services)
- 0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay) (Centers for Medicare & Medicaid Services)
- 2828 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Centers for Medicare & Medicaid Services)⁴
- 3039 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Centers for Medicare & Medicaid Services)⁵
- 3070 Preventive Care and Screening: Influenza Immunization (PCPI Foundation)
- 3086 Population Level HIV Viral Load Suppression (Centers for Disease Control and Prevention)

One measure received Inactive Endorsement with Reserve Status:

- 1659 Influenza Immunization (Centers for Medicare & Medicaid Services)

The three measures approved for Trial Use are:

- 3059 One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk (PCPI Foundation)
- 3060 Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users (PCPI Foundation)
- 3061 Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection (PCPI Foundation)

The following six measures are not endorsed:

- 3067 Human Immunodeficiency Virus (HIV) Infection Screening (Centers for Disease Control and Prevention)
- 3071 Follow-up Referral after Positive Developmental Screen (Northwestern University)
- 3087 Completion of a Malnutrition Screening within 24 hours of Admission (Avalere Health/Academy of Nutrition and Dietetics)
- 3088 Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening (Avalere Health/Academy of Nutrition and Dietetics)
- 3089 Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment (Avalere Health/Academy of Nutrition and Dietetics)
- 3090 Appropriate Documentation of a Malnutrition Diagnosis (Avalere Health/Academy of Nutrition and Dietetics)

Brief summaries of the measure reviews are included in the body of the report; detailed summaries of the Committee's discussion and ratings of the criteria for each measure are in [Appendix A](#).

Introduction

The United States spends more per capita on healthcare than any country, but our population, as a whole, is the least healthy in the developed world.⁶ Many people think of medical care when talking about how to improve the health and well-being of individuals and populations. Medical care, however, has a relatively small influence on overall health when compared with behaviors such as smoking and poor diet, physical environmental hazards, such as polluted air and unsafe roadways, and social factors like low educational achievement and poverty.⁷ Maintaining and improving the health and well-being of individuals and populations requires a multidisciplinary, multifactorial approach. Social, environmental, economic, and behavioral factors all play a significant role. These and other determinants of health contribute up to 60 percent of deaths in the United States,⁸ yet less than 5 percent of health expenditures are spent on prevention.⁹

While this project focused on measure endorsement, the National Quality Forum's (NQF) work in health and well-being extends well beyond measure endorsement, and includes projects focused on [reducing disparities in health outcomes](#) and promoting and coordinating multistakeholder communities to improve local population health. For example, to consider how performance measurement could accelerate improvements in population health, NQF commissioned a report to define concepts and identify the challenges and opportunities to align health improvement activities and measurement across the clinical care and government public health systems ([Jacobson and Teutsch, 2012](#)). To be proactive, NQF also has provided guidance on measure evaluation for [population health](#) and [access](#) measures to promote measure development in these areas.

Focusing on communities is key to improving the health and well-being of individuals and of the population. Although quality improvement and measurement overwhelmingly have focused on clinical care and healthcare delivery, evidence documents that effective programs and policies that promote health can prevent disease, increase productivity, and yield billions of dollars in savings for the U.S. healthcare system. With the right measures and a collaborative approach with key stakeholders whose policies, practices, and procedures influence health and healthcare, improvement in the health and well-being of individuals and communities has the potential to reduce mortality and excess morbidity effectively and significantly. In this regard, NQF has produced a community-focused [guidebook](#) for improving population health and well-being.

NQF's Health and Well-Being portfolio of measures includes measures for health-related behaviors to promote healthy living; community-level indicators of health and disease; modifiable social, economic, and environmental determinants of health; primary prevention and/or screening; and oral health (see [Appendix B](#)). Measures reviewed in this phase of the project focused primarily on primary prevention and/or screening. [Previous phases](#) included several community-level indicators of health and disease and measures oral health.

Trends and Performance

The 2015 National Healthcare Quality and Disparities Report¹⁰ identified several trends and disparities related to measures of health and well-being. The Agency for Healthcare Research and Quality (AHRQ) found that, based on the measures used to assess the NQS priority of Healthy Living, progress lagged

behind the other five priorities. It reported that, overall, receipt of recommended clinical preventive services has not increased substantially over the past decade. On a positive note, however, AHRQ reported disparities were uncommon for the Healthy Living Measures and, where they existed, were getting smaller.

NQF Portfolio of Performance Measures for Health and Well-Being

The Health and Well-Being Standing Committee (see [Appendix D](#)) oversees NQF’s portfolio of health and well-being measures that includes measures for Community-Level Indicators of Health and Disease; Health-Related Behaviors and Practices to Promote Healthy Living; Modifiable Social, Economic, and Environmental Determinants of Health; Oral Health; and Primary Prevention and/or Screening (see [Appendix B](#)). This portfolio contains 47 measures: 27 process measures, 17 outcome and resource use measures, and three structural measure (Table 1).

Table 1. NQF Health and Well-Being Portfolio of Measures

	Process	Outcome/ Resource Use	Structural	Composite
Community-Level Indicators of Health and Disease	0	10	1	0
Health-Related Behaviors and Practices to Promote Healthy Living	2	2	2	0
Modifiable Social, Economic, and Environmental Determinants of Health	0	1	0	0
Oral Health	6	4	0	0
Primary Prevention and/or Screening	19	0	0	0
Total	27	17	3	0

Additional measures related to population health and health and well-being are assigned to other projects. These include measures in the Pulmonary Critical Care project like 0283 *Asthma in Younger Adults Admission Rate (PQI 15)* (Agency for Healthcare Research and Quality); 0275 *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 05)* (Agency for Healthcare Research and Quality); several diabetes assessment and screening measures (Endocrine project/Behavioral Health project); eye care measures (EENT project); ACEI/ARB medication measures (Cardiovascular project); complications and outcomes measures (Health and Well-Being/Surgery projects); and one cost and resource use measure (Cost and Resource Use project).

National Quality Strategy

NQF-endorsed measures for health and well-being help support the [National Quality Strategy \(NQS\)](#) and the [National Prevention Strategy \(NPS\)](#). NQS serves as the overarching framework for guiding and aligning public and private efforts across all levels (local, state, and national) to improve the quality of healthcare in the United States. The NQS establishes the "triple aim" of better care, affordable care, and

healthy people/communities, focusing on six priorities to achieve those aims: *Safety, Person and Family Centered Care, Communication and Care Coordination, Effective Prevention and Treatment of Illness, Best Practices for Healthy Living, and Affordable Care*. The NPS serves as the overarching framework for improving the quality of life for individuals, families, and communities by shifting the nation's focus from sickness and disease to prevention and wellness. It established four strategic directions to guide actions with demonstrable improvements in health: Healthy and Safe Community Environments, Clinical and Community Preventative Services, Empowered People, and Elimination of Health Disparities.

Quality measures for health and well-being align with several of the NQS and NPS priorities. The NQF portfolio of measures includes those that support preventive services, as envisioned by both the NQS and NPS. For this project, measures addressing effective prevention and treatment of illness and clinical and community preventive services include:

- 0032 Cervical Cancer Screening (CCS);
- several measures for influenza immunization;
- three hepatitis C virus screening and follow-up measures for Trial Use (3059, 3060, 3061); and
- 0421 and 3039 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (paper and eMeasure).

Existing NQF-endorsed measures in the portfolio support other priorities. For example, 2695 *Follow-Up after Emergency Department Visit by Children for Dental Caries* supports *Best Practices for Healthy Living*, and 0638 *Uncontrolled Diabetes Admission Rate (PQI 14)* supports *Communication and Care Coordination*.

Use of Measures in the Portfolio

Endorsement of measures by NQF is valued not only because the evaluation process itself is both rigorous and transparent, but also because evaluations are conducted by multistakeholder committees composed of clinicians and other experts from the full range of healthcare providers, employers, health plans, public agencies, community coalitions, and patients—many of whom use measures on a daily basis to ensure better care. Moreover, NQF-endorsed measures undergo routine "maintenance" (i.e., re-evaluation) to ensure that they are still the best-available measures and reflect the current science. Importantly, federal law requires that preference be given to NQF-endorsed measures for use in federal public reporting and performance-based payment programs. NQF measures also are used by a variety of stakeholders in the private sector, including a wide range of providers (e.g., physician practices, hospitals, skilled nursing facilities, dialysis clinics), health plans, and states and counties.

Various federal and private programs are using measures considered for endorsement during this phase of the Health and Well-Being project. Several of the maintenance measures reviewed are currently used in CMS programs such as the Medicare Shared Savings Program (MSSP), Physician Value-Based Payment Modifier (VBM), Medicare Physician Quality Reporting System (PQRS), and the Merit-Based Incentive Payment System (MIPS). See [Appendix C](#) for specific details of federal program use for the measures reviewed.

Improving NQF's Health and Well-Being Portfolio

Gaps in the Portfolio

The measurement gap areas in the Health and Well-Being portfolio emphasize the need for measures that assess upstream determinants of health. These gaps previously were identified by this Committee and through the Measure Applications Partnership (MAP) Population Health Family of Measures, in which MAP recommended areas for future measure development to the Centers for Medicare & Medicaid Services (CMS) for possible use in federal programs. Such measures could assess social, economic, and environmental determinants of health; physical environment (e.g., built environments); policy (e.g., smoke-free zones); specific subpopulations (e.g., people with disabilities, elderly people); patient and population outcomes linked to improvement in functional status; counseling for physical activity and nutrition in younger and middle-aged adults (18 to 65 years); and composites that assess population experience. Additionally, more disparities-sensitive measures are needed, as well as those that assess access to care. Building on prior disparities work, NQF's Disparities Standing Committee provides strategic direction and guidance to NQF and the measurement field on enhancing measure development activity and promoting growth of the NQF portfolio of disparity-sensitive and cultural competency measures.

Refining the NQF Measure Evaluation Process

The New Endorsement and Appeals Process

In August 2016, NQF implemented changes to its ratification and appeals process that were initiated and approved by its Board of Directors. Following public comment and voting by the NQF membership, the Consensus Standards Approval Committee (CSAC) will make the final measure endorsement decision, without ratification by another body. Additionally, the Board requested NQF to establish a five-member Appeals Board that will be responsible for adjudicating all submitted appeals regarding measure endorsement decisions.

The newly constituted Appeals Board, composed of NQF Board members and former CSAC and/or committee members, will adjudicate appeals to measure endorsement decisions without a review by the CSAC. The decision of the Appeals Board will be final.

All submitted appeals will be published on the NQF website. Staff will compile the appeals for review by the Appeals Board, which will evaluate the concerns raised and determine if the appeal should warrant overturning the endorsement decision. Decisions on an appeal of endorsement will be publicly available on NQF's website.

Throughout the process, project staff will serve as liaisons between the CSAC, the Appeals Board, the committee, developers/stewards, and the appellant(s) to ensure the communication, cooperation, and appropriate coordination to complete the project efficiently.

Health and Well-Being Measure Evaluation

On September 12-13, 2016, the Health and Well-Being Standing Committee evaluated 12 new measures and 11 measures undergoing maintenance review against [NQF's standard evaluation criteria](#). At the in-person meeting, 10 measures were recommended for endorsement, one measure was recommended

for Inactive Endorsement with Reserve Status, three measures were approved for trial use, and the Committee did not recommend/reach consensus on nine measures.

During the post-comment call on December 6, 2016, the Committee discussed public comments received; re-evaluated six measures where consensus was not reached; reviewed a request for reconsideration; and discussed the harmonization of influenza vaccination measures. Of the six measures where consensus was not reached, four measures were recommended for endorsement, and two measures were not recommended. The Committee also considered a developer’s request for reconsideration, but voted against reconsideration, so the measure remains not recommended for endorsement.

Table 2. Health and Well-Being Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	11	12	23
Measures endorsed	10	3	13
Measures approved for inactive endorsement with reserve status	1	—	1
Measures approved for trial use	—	3	3
Measures not endorsed	—	6	6
Measures withdrawn from consideration	18	1	19
Reasons for not recommending	Importance – 0 Scientific Acceptability – 0 Overall – 0 Competing Measure – 0	Importance – 3 Scientific Acceptability – 3 Overall – 0 Competing Measure – 0	

Evaluation of eMeasures for Trial Use

The Standing Committee evaluated three new eMeasures for NQF approval for trial use. NQF approval for trial use is intended for eMeasures that are ready for implementation, but have not yet been adequately tested to meet NQF endorsement criteria. NQF uses the multistakeholder consensus process to evaluate and approve eMeasures for trial use that address important areas for performance measurement and quality improvement, though they may not have the requisite testing needed for NQF endorsement. These eMeasures must be assessed to be technically acceptable for implementation. The goal for approving eMeasures for trial use is to promote implementation and the ability to conduct more robust reliability and validity testing that can take advantage of clinical data in EHRs.

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the [Quality Positioning System \(QPS\)](#). In addition, NQF solicits comments prior to the evaluation of the measures via an online tool located on the project webpage. For this evaluation cycle, the pre-evaluation comment period was

open from August 11-August 23, 2016, for 23 of the 24 measures under review.^a No pre-evaluation comments were received.

Overarching Issues

During the Standing Committee’s discussion of the measures, several overarching issues emerged that were factored into the Committee’s ratings and recommendations for multiple measures and are not repeated in detail with each individual measure.

Lack of Universal Influenza Immunization Measure

In its last maintenance evaluation of influenza immunization measures, the Committee strongly recommended the development of a universal influenza immunization measure, in contrast to the proliferation of care setting-specific measures; the Committee also noted that several measures were not harmonized to the NQF’s standardized specifications.¹¹ For this phase, the Committee again reviewed eight influenza immunization measures for maintenance of endorsement. While most were now harmonized to NQF’s standardized specifications, the Committee reiterated the need for a single, standardized measure even though multiple developers are involved.

Level of Analysis

During its discussions, the Committee was cognizant of a measure’s locus of accountability—i.e., the developer’s stated level of analysis. For example, during the review of the AHRQ population-level measure on community-acquired pneumonia (0279), the Health and Well-Being Committee was made aware that the Pulmonary and Critical Care Standing Committee, which had reviewed the measure, had previously identified a concern about “off-label” use: The federal government is using the measure at the practice level (specifically, as a part of the Value-Based Modifier Program), but the endorsement is at the population level. The Health and Well-Being Committee also expressed strong concern about using measures for levels of analysis beyond what was tested by the developer and endorsed by NQF. This Committee emphasized that its recommendations for every measure are based on the developer’s intended use, for which testing has been conducted; implementation at nonendorsed levels of accountability after the fact does not comport with its review and recommendations.

Series of Process Measures vs. Intermediate Outcome or Outcome Measures

Although Committee members appreciated the increased diversity of new measure topics in this project phase, they expressed frustration with evaluating isolated process measures of a multistep process, when it’s the entire process that affects health and well-being, not the individual steps. The Committee noted that several of the new process measures assessed steps that were distal from an intermediate outcome or (final) outcome. Committee members acknowledged that “early step” process measures were a start, but expressed frustration at the lack of more holistic measures and emphasized the importance of

^a 0279 *Bacterial Pneumonia Admission Rate (PQI 11)* [changed to *Community Acquired Pneumonia Admission Rate*] (Agency for Healthcare Research and Quality) initially was reviewed by the Pulmonary Standing Committee from March-June 2016. The Consensus Standards Approval Committee referred the measure to the Health and Well-Being Standing Committee for additional consideration; this referral occurred after the pre-evaluation comment period. One measure, 3062 *Hypertension Screening for Children Who Are Overweight or Obese* was available for pre-evaluation comment but was withdrawn prior to final Committee evaluation.

developing measures that are close to the desired outcome. In general, the Committee most desires that an individual process measure used to hold providers accountable be more distal from the first step in the process; it also recommended developers consider composite measures. Finally, the Committee strongly urged development of measures that looked at intermediate outcomes or (final) outcomes.

Clinical Guidelines and Systematic Reviews

The Committee discussed unevenness and bias in guidelines, systematic reviews, and grading. It noted the need to assess the risk of bias in guidelines/reviews overall, as well as the underlying studies, when considering the Evidence criterion. Committee members also emphasized the importance of interpreting guidelines as they apply to a measure, specifically, and not over-extending or over-interpreting a guideline with broad strokes if the recommendation is narrowly cast.

Lack of Measures of Upstream Determinants

Committee members again noted the lack of measures that assess upstream determinants of health. As noted earlier in the discussion on the gaps in NQF's Health and Well-Being portfolio, measures that assess social, economic, and environmental determinants of health—e.g., physical environment (e.g., built environments) and policy (e.g., smoke-free zones)—could be important drivers to improve health and well-being.

Summaries of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues for each measure that the Standing Committee considered. Details of the Committee's discussion and ratings of the criteria for each measure are included in [Appendix A](#).

Endorsed Measures

0032 Cervical Cancer Screening (CCS) (National Committee for Quality Assurance): Endorsed

Description: Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every 3 years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.; **Measure Type:** Process; **Level of Analysis:** Health Plan, Integrated Delivery System; **Setting of Care:** Ambulatory Care: Clinician Office/Clinic; **Data Source:** Administrative claims, Electronic Clinical Data, Paper Medical Records

This maintenance measure, first endorsed in 2009, focuses on cervical cancer screening, which is a secondary prevention that has been shown to improve health outcomes by detecting cervical cancer in its earlier, more treatable stages. The United States Preventive Services Taskforce's (USPSTF) guidelines for cervical cancer screening have been updated since 2012; however, the updates do not affect the evidence base. The Committee accepted the prior evaluation of this criterion without further discussion.

Due to the unchanged performance rates for commercial plans, the Committee questioned whether the measure was topped out, but the developer explained that wide variation exists and cited literature revealing significant access barriers to regular cervical cancer screening for recent immigrants and

women without health insurance. A Committee member also noted that data show that Hispanic and African-American women have the highest incidence of cervical cancer, respectively. Performance data are not currently stratified by sociodemographic variables due to challenges in incorporating the data into HEDIS in a standardized way, but the Committee strongly recommended that the developer include this information for the next maintenance review; the developer agreed to do so. After some discussion of the included populations, the developer agreed to consider the Committee's concerns related to cervical cancer screening in high-risk women over 65 years of age. Since reliability testing remains unchanged since the last maintenance review, the Committee accepted the prior evaluation of this criterion without further discussion. The measure has both face and empirical validity testing, and the Committee agreed that the results were acceptable. The Committee noted concern that "some," not all data elements are available in electronic sources but agreed that the measure is feasible. The measure is currently in use in several public reporting and payment programs. The Committee recommended NQF #0032 for continued endorsement.

0038 Childhood Immunization Status (CIS) (National Committee for Quality Assurance: Endorsed

Description: Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and a combination rate.; **Measure Type:** Process; **Level of Analysis:** Health Plan, Integrated Delivery System; **Setting of Care:** Ambulatory Care: Clinician Office/Clinic; **Data Source:** Administrative claims, Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data: Registry

This maintenance measure consists of individual rates of children who received the recommended vaccines by their second birthday (diphtheria, tetanus, and acellular pertussis; polio; measles, mumps, and rubella; haemophilus influenza type B; hepatitis B; hepatitis A; chicken pox; pneumococcal conjugate; rotavirus; and influenza) and an all-10 composite. The measure is based on the CDC's 2011 ACIP recommendations for individual, recommended childhood immunizations and aligns with the updated 2015 ACIP recommendations; the Committee agreed to accept the prior evaluation of the Evidence. The developer provided performance rates for each of the 10 immunizations and the all-10 composite by commercial versus Medicaid plan. The developer does not collect data stratified by race, ethnicity, or language; however, the developer cited literature related to disparities and childhood immunizations. While the Committee agreed that the measure met the performance gap criteria, it strongly urged the developer to assess disparities, and the developer agreed to do so for the next review. Because the submission includes the all-10, all-or-nothing composite, the Committee also assessed the composite quality construct and rationale. The developer did not provide an explicit rationale for the composite, although it can be inferred based on the ACIP recommendations for the individual childhood immunizations, all of which are recommended. The Committee stressed the importance of assessing individual components to identify meaningful performance gaps, but did not reach consensus on the Composite Quality Construct and Rationale. Some Committee members expressed reservations about the all-10 composite, noting that performance overall has the appearance of being potentially low (mean for commercial plans in 2014 of 47.57 percent and for Medicaid plans, 36.1 percent), but in fact,

performance on the individual vaccines varies widely and is more informative on where problems should be addressed. The beta-binomial method was used to assess signal-to-noise, and the updated reliability results, based on the 2014 HEDIS data, were strong, so the Committee accepted the prior Reliability evaluation without further discussion. A multistakeholder panel had previously conducted Validity testing; the Committee accepted the prior Validity evaluation without further discussion. The measure has been in use in several public reporting and payment programs, and the Committee had no major concerns with the feasibility or usability. The developer reports that during the last five years, performance has improved, but significant room for improvement in individual vaccines and across plans remains, so it believes the use of the measure is making an impact. The Committee did not vote on an overall endorsement recommendation for NQF #0038 because consensus was not reached on the Composite Quality Construct. Prior to the post-comment call, the developer withdrew the component of the specifications that pertains to the all-10 composite. During the post-comment call, the Committee noted that since the part of the specifications in question had been removed, the measure was no longer controversial. The Committee voted on Overall Suitability for Endorsement, and the measure was recommended for endorsement.^b

0039 Flu Vaccinations for Adults Ages 18 and Older (National Committee for Quality Assurance): Endorsed

Description: The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure is collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, and commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older; **Measure Type:** Process ; **Level of Analysis:** Health Plan, Integrated Delivery System; **Setting of Care:** Ambulatory Care: Clinician Office/Clinic, Home Health, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility: Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility: Long Term Acute Care Hospital, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility, Pharmacy, Ambulatory Care: Urgent Care; **Data Source:** Patient Reported Data/Survey

NQF #0039 was originally endorsed in 2009. Evidence suggests that influenza vaccinations are the most effective way to prevent severe illness or death resulting from influenza and its complications. This process measure uses the 2015-2016 Advisory Committee on Immunization Practices (ACIP) recommendations for influenza vaccinations. In 2014, the maximum rate for commercial plans was 59.4 percent and for Medicaid, 50.4 percent; the Committee agreed there is a performance gap with room for improvement. The developer currently does not receive race and ethnicity data or other data stratified by sociodemographic variables like education, income, or language preference; however, the literature notes differences in coverage rates by race and ethnicity. The Committee stressed the importance of assessing disparities in order to provide targeted solutions in at-risk communities. The developer agreed to include disparities data in the next maintenance submission.

^b On the post-comment call, the number of Committee members who participated was n=14, but participation varied and, for a few votes, quorum (n=12) was not maintained. Under these circumstances, the decision was made that Committee members who were not present for all votes would be provided a summary of the discussions and be asked to vote on those items for which they had not been present—thus ensuring that for each voting item n=14. It was emphasized that none of the vote tallies on the call were final.

After reviewing some updates to the specifications, the Committee accepted the prior reliability testing. Validity testing methods included face validity, construct validity, and cognitive testing; the Committee agreed that the results demonstrate sufficient validity. The CAHPS survey is conducted by third-party vendors via telephone, mail, email, or mixed protocols. The developer noted concerns that moving to an internet-based survey could potentially bias results, as older more frail adults may be less likely to complete the survey. The Committee raised concern that “some,” not all, data elements are in defined fields in electronic sources, but agreed that the measure is feasible. The measure is used in several public reporting and payment programs, including NCQA Health Plan Ranking; NCQA Annual State of Health Care Quality; NCQA Quality Compass; NCQA Accreditation and Disease Management Accreditation; CMS Medicaid Adult Core Set; and CMS Medicare Advantage Star Rating. There are several related measures; this measure is not fully harmonized since it is only collected through a patient survey. Ultimately, the Committee agreed that NQF #0039 met the NQF criteria and recommended it for continued endorsement.

0041 Preventive Care and Screening: (Influenza Immunization [PCPI]): Endorsed

Description: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization; **Measure Type:** Process ; **Level of Analysis:** Clinician: Group/Practice, Clinician: Individual; **Setting of Care:** Ambulatory Care: Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility, Other; **Data Source:** Electronic Clinical Data, Electronic Clinical Data: Registry

This maintenance measure, first endorsed in August 2009 and maintained in May 2012, focuses on influenza immunization for patients six months and older. The Centers for Disease Control and Prevention (CDC) updated its guideline to reflect the recommendations of its Advisory Committee on Immunization Practices (ACIP), which states that all persons older than six months of age receive an influenza vaccination annually. Committee members questioned whether the measure had broad applications beyond primary care settings, to which the developer affirmed that the measure can be used across subspecialties and care settings. The Committee noted disparities in rates of vaccination by location, age, race, and ethnicity, and agreed that performance gaps in care remain. This measure does not align with NQF’s standard specifications for influenza vaccinations. Specifically, the numerator statement does not include offer/decline; the denominator statement does not differentiate high-risk conditions in patients 19-49 years of age; the medical, patient, and system exclusion reasons did not align; and the measure does not acknowledge early availability of the vaccination. Nonetheless, this measure passed the Importance and Scientific Acceptability criteria. Data for this measure are generated or collected by the healthcare personnel during the provision of care and then coded by a second person. All data elements are in defined fields in a combination of electronic sources. This measure is currently used by the Physician Quality Reporting System. The Standing Committee recommended NQF #0041 for continued endorsement.

0226 Influenza Immunization in the ESRD Population (Facility Level) (Kidney Care Quality Alliance): Endorsed

Description: Percentage of end stage renal disease (ESRD) patients aged 6 months and older receiving hemodialysis or peritoneal dialysis during the time from October 1 (or when the influenza vaccine

became available) to March 31 who either received, were offered and declined, or were determined to have a medical contraindication to the influenza vaccine; **Measure Type:** Process ; **Level of Analysis:** Facility; **Setting of Care:** Dialysis Facility; **Data Source:** Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records

This maintenance measure, first endorsed in 2007 and most recently maintained in 2012, focuses on influenza immunizations among patients six months of age or older who receive hemodialysis and peritoneal dialysis for end stage renal disease (ESRD). Influenza immunization has been shown to decrease the likelihood of hospitalization, morbidity, and mortality among ESRD patients. The 2012 NQF Committee noted high ratings on quantity, quality, and consistency of evidence. The measure was deemed appropriate by expert opinion from the Kidney Care Partners and Kidney Care Quality Alliance, as well as the expert opinion of the NQF ESRD Technical Advisory Panel. The measure also received broad agreement through the NQF review and voting process. The measure is coded by someone other than the person who originally obtained the information. NQF #0226 is currently used in internal quality improvement, and the developer states that it is working with CMS on inclusion in the ESRD Quality Incentive Program. Nine measures were identified as related and competing to this measure; NQF #0226 is fully harmonized with the NQF standard specifications. The Committee recommended NQF #0226 for continued endorsement.

0279 Bacterial Pneumonia Admission Rate (PQI 11) (Agency for Healthcare Research and Quality): Endorsed

Description: Admissions with a principal diagnosis of bacterial pneumonia per 1,000 population, ages 18 years and older. Excludes sickle cell or hemoglobin-S admissions, other indications of immunocompromised state admissions, obstetric admissions, and transfers from other institutions; **Measure Type:** Outcome; **Level of Analysis:** Population: County or City; **Setting of Care:** Other; **Data Source:** Administrative claims

NQF #0279 is a population quality indicator specified for county or city-level populations. It aims to provide an assessment of population health for pneumonia at a health system level by measuring the rate of pneumonias requiring hospitalizations, which can be improved by access to quality care and community resources that promote improved population health. The Pulmonary and Critical Care Standing Committee initially reviewed the measure, but the Consensus Standards Approval Committee (CSAC) referred it to the Health and Well-Being Standing Committee for further review. The developer provided updated evidence related to hospitalization for pneumonia, but the underlying rationale for this outcome measure has not changed since the last NQF endorsement review.

Variation in performance between counties was closely linked to income level. Committee members debated the appropriateness of risk adjustment for socioeconomic factors like income, but believed that risk-adjustment might mask disparities across subpopulations and suggested stratification instead. Similar to the Pulmonary and Critical Care Standing Committee, the Health and Well-Being Committee expressed significant concern about the unintended consequences of measure misuse. The measure is neither specified nor intended for use to measure the performance of any particular provider, individual clinician, or hospital; however, it is currently being used in the CMS Medicare FFS Physician Feedback Program/Value-Based Payment Modifiers and Quality and Resource Use Reports (QRUR). The

Committee emphasized that such implementation is not appropriate because testing and endorsement review occur at the specified level. At the same time, Committee members acknowledged the value of population-level measures such as this type. The Committee agreed that the measure met the NQF criteria and recommended NQF #0279 for continued endorsement.

0431 Influenza Vaccination Coverage Among Healthcare Personnel (Centers for Disease Control and Prevention): Endorsed

Description: Percentage of healthcare personnel (HCP) who receive the influenza vaccination; **Measure Type:** Process ; **Level of Analysis:** Facility; **Setting of Care:** Ambulatory Care: Ambulatory Surgery Center (ASC), Ambulatory Care: Clinician Office/Clinic, Dialysis Facility, Hospital/Acute Care Facility, Behavioral Health/Psychiatric: Inpatient, Post Acute/Long Term Care Facility: Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility: Long Term Acute Care Hospital, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility; **Data Source:** Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Management Data, Paper Medical Records, Patient Reported Data/Survey

NQF #0431 is a maintenance measure, first endorsed in 2007, that assesses the percentage of healthcare personnel (HCP) who receive the influenza vaccination. The measure is based on the 2010 Centers for Disease Control and Prevention guidelines that state that all healthcare professionals should be vaccinated annually against influenza. While the data showed an upward trend for acute care hospitals, there remains an opportunity for improvement; the mean performance across different facilities ranged from 76 percent to 88 percent. The developer noted continuing significant performance gaps across types of facilities, personnel, and geographic regions. Since the measure examines summary vaccination data at the facility level, data on individual differences in vaccination by race, ethnicity, gender, age, or other sociodemographic variables are not available.

For reliability testing, the developer performed inter-rater reliability and case studies. Committee members noted lack of geographic variation in the testing sample population, with no representation from the Midwest and South. One Committee member noted that at least two of the four states recruited for measure testing (New York and California) require HCP be vaccinated or wear a mask; these mandates may skew performance results. Convergent validity was assessed using a one-way ANOVA, and face validity was assessed in 2011 using a modified Delphi technique via a nine-member expert panel. After discussion, the Committee agreed that the measure met the scientific acceptability criterion. The developer was unable to quantify the data collection burden, and acknowledged challenges for facilities without appropriate electronic records systems. Overall, however, the Committee agreed that the measure was feasible. The measure is currently used in several federal programs. The measure is aligned with the NQF standard specifications for influenza vaccinations; however, as with the standard specifications, the three numerator populations should be computed and reported separately. Ultimately, the Committee agreed that NQF #0431 met the NQF criteria and recommended it for continued endorsement.

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay) (Centers for Medicare & Medicaid Services): Endorsed

Description: The measure reports the percentage of short-stay residents or patients who are assessed and appropriately given the seasonal influenza vaccine during the most recently-completed influenza

season. The influenza vaccination season (IVS) is defined as beginning on October 1, or when the vaccine first becomes available, and ends on March 31 of the following year. This measure is based on the NQF's National Voluntary Standards for Influenza and Pneumococcal Immunizations; **Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Post Acute/Long Term Care Facility: Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility: Long Term Acute Care Hospital, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility; **Data Source:** Electronic Clinical Data

NQF #0680 is a maintenance measure that assesses influenza vaccine administration for short-stay residents or patients in nursing homes, skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF), and long-term care hospitals (LTCH); short-stay is defined as 100 days or fewer. The measure was initially endorsed in 2011 and focused solely on nursing homes. In 2012, an ad hoc review by the developer prompted expansion of the measure's population to IRFs and LTCHs. The developer presented the most recent guideline recommendations from the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP). The Committee agreed that the underlying evidence for this process measure has not changed since the last update and accepted the prior evaluation. The Committee agreed that 2014-2015 performance rates demonstrated considerable variation and an opportunity for improvement. In particular, males, Caucasians, and older individuals were more likely to receive the vaccine, and women, African-Americans, Hispanics, and younger individuals were more likely to decline the vaccine across all of the settings. The developer also noted disparities between urban and rural facilities. The developer provided inter-rater reliability results using the nursing home database (MDS), where influenza related items were assessed on 94 patients from April 1 to December 31, 2006. Testing was not conducted on the reliability of the influenza measure items from the LTCH Care Data Set or the IRF-PAI. The developer stated that it is reasonable to apply the reliability testing from the MDS to the LTCH CARE Data Set and the IRF-PAI, but also noted that the populations are not identical and some differences in reliability may exist. Committee members also raised concerns about the face validity assessment; the developer provided additional specificity on the assessment and nature of the panel's composition. Overall, NQF staff and several Committee members found the testing data difficult to interpret. The developer agreed to work with NQF following the in-person meeting to clarify any remaining concerns. The Committee did not vote on an overall endorsement recommendation for NQF #0680 because consensus was not reached on Reliability and Validity. Following the in-person meeting, the measure developer worked with NQF to bring forward additional testing data for the additional care settings. The developer submitted these details on testing methodology and results for LTCHs and IRFs. On the post-comment call, the Committee believed that the new data sufficiently addressed its concerns. The Committee re-voted on Reliability, Validity, and Overall Suitability and ultimately recommended the measure for continued endorsement.^c

^c On the post-comment call, the number of Committee members who participated was n=14, but participation varied and, for a few votes, quorum (n=12) was not maintained. Under these circumstances, the decision was made that Committee members who were not present for all votes would be provided a summary of the discussions and be asked to vote on those items for which they had not been present—thus ensuring that for each voting item n=14. It was emphasized that none of the vote tallies on the call were final.

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay) (Centers for Medicare & Medicaid Services): Endorsed

Description: This measure reports the percentage of long-stay residents, 180 days of age and older, who were in a nursing facility for at least one day during the most recently completed influenza vaccination season (IVS), and who were assessed and appropriately given the seasonal influenza vaccine. The IVS is defined as beginning on October 1 and ends on March 31 of the following year. The measure is the aggregate of three separately calculated submeasures to reflect the process by which a resident is assessed and appropriately given the influenza vaccination during the current or most recent influenza season; **Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Post Acute/Long Term Care Facility; Nursing Home/Skilled Nursing Facility; **Data Source:** Electronic Clinical Data

NQF #0681 was originally endorsed in 2011; it is specified for nursing home and skilled nursing facilities and is intended to ensure that all long-stay residents are assessed and administered the seasonal influenza vaccine. The evidence is closely aligned with NQF #0680, which assesses influenza vaccine administration for short-stay in post-acute/long-term care facilities; both measures are harmonized to the extent possible.

The developer provided reliability and validity testing using the Minimum Data Set (MDS), an electronic reporting system for skilled nursing facilities. Inter-rater reliability results, where influenza related items were assessed on 94 patients from April 1 to December 31, 2006, yielded a 13.1 percent discrepancy rate between the nursing facility assessment and the nurse reviewer. The measure is in use in the Nursing Home Quality Reporting Program. The developer reported that the mean performance increased from the 2011-2012 IVS (92.6 percent) to the 2012-2013 IVS (93.6 percent); it decreased for the 2014-2015 IVS (93.2 percent). The developer noted that the magnitude of these changes is small, and the changes may be due to confounding factors, rather than performance. The Committee agreed that the measure met the NQF criteria and recommended NQF #0681 for continued endorsement.

2828 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Quality Insights of Pennsylvania): Endorsed

Description: Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter: Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30 , Age 18 – 64 years BMI ≥ 18.5 and < 25 ; **Measure Type:** Process; **Level of Analysis:** Clinician: Group/Practice, Clinician: Individual; **Setting of Care:** Ambulatory Care: Clinician Office/Clinic; **Data Source:** Electronic Clinical Data: Electronic Health Record

This is the new eMeasure of the claims-based NQF #3039 (formerly 0421). The information provided for Evidence and Performance Gap is identical to that submitted for NQF #3039. The ratings for Evidence and Performance Gap from NQF #3039 were automatically assigned to this eMeasure without further [discussion](#). For this eMeasure, HQMF specifications were provided. The general purpose statements and inclusion/exclusions of the value sets were not included, but will be provided following the trial period. Reliability testing was conducted on the performance score using data collected from three primary care practices and two types of data from their EHRs: (1) an extract containing patient-level data for all

eligible patients and (2) a manual abstraction of a simple random sample of 104 or 105 patient records from each practice. The Committee agreed that the testing results met the NQF criteria for Reliability and Validity. Most of the data elements in the measure are included in defined EHRs fields; some are in unstructured fields. A feasibility assessment was provided with this eMeasure submission. The claims-based version of this measure is included in PQRS, and the electronic measure is included in Meaningful Use, but data are not yet available on the frequency of use in Meaningful Use. The Committee agreed that this eMeasure, NQF #2828, meets the NQF criteria and recommended it for endorsement.

3039 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Quality Insights of Pennsylvania): Endorsed

Description: Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter:

Normal Parameters:

Age 65 years and older BMI ≥ 23 and < 30 kg/m²

Age 18–64 years BMI ≥ 18.5 and < 25 kg/m²; **Measure Type:** Process; **Level of Analysis:** Clinician:

Group/Practice, Clinician: Individual; **Setting of Care:** Ambulatory Care: Clinician Office/Clinic; **Data**

Source: Administrative claims, Electronic Clinical Data: Registry

This maintenance measure (formerly NQF #0421) is the claims-based version of eMeasure #2828. NQF #3039 addresses the importance of body mass index (BMI) measurement and follow-up when the measurement is outside normal parameters. More than one-third of adults in the United States are obese, and obesity in adults younger than 65 years has been shown to reduce life expectancy and increase medical costs. Weight loss has been shown to decrease blood pressure, reduce triglycerides, and decrease blood glucose levels and hemoglobin A1c, all of which may slow the progression of type two diabetes and cardiovascular disease. This measure, which is intended for all eligible providers, including social workers, psychologists, physical therapists, and occupational therapists, requires documentation of a follow-up plan when a BMI outside normal parameters has been identified. Because the measure does not specify specific requirements for the follow-up plan, some Committee members were skeptical that the measure would be able to influence behavior without a specific, robust follow-up plan; others believed that it is a good first step in addressing BMI and associated health issues. While rates have been improving (2.7 percent of eligible professionals in 2011, versus 19.2 percent in 2014), an opportunity for improvement remains.

Performance score and signal-to-noise analyses were conducted for reliability testing, as well as face validity testing; the Committee had no major concerns with the scientific acceptability of the measure. Based on past use, the measure is feasible to report; the measure is currently in use in PQRS and is one of the top five reported measures, with more than 105,000 eligible physicians reporting. The Committee noted, however, there are implementation barriers, including variability in how BMI outside normal parameters is captured in different electronic health record systems; some capture these data in structured fields and others in unstructured fields. While the Committee recommended NQF #3039 for continued endorsement, it also recommended that the developer specify requirements for the follow-up plan, e.g., including intervention strategies like motivational interviewing or gym referrals, which have a strong link to improved patient outcomes. The Committee also recommended that the developer

better align the specifications with the U.S. Preventive Services Task Force’s current guidelines related to the appropriate referral population (obese vs. overweight).

3070 Preventive Care and Screening: Influenza Immunization (PCPI): Endorsed

Description: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization; **Measure Type:** Process; **Level of Analysis:** Clinician: Group/Practice, Clinician: Individual; **Setting of Care:** Ambulatory Care: Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility, Other; **Data Source:** Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record

This is the eMeasure version of the claims-based Measure #0041: Preventive Care and Screening: Influenza Immunization, which assesses annual influenza immunization for all people aged > six months, as recommended by the CDC’s Advisory Committee on Immunization Practices (ACIP). This measure, however, is not fully aligned with NQF’s standard specifications for influenza vaccinations. Several Committee members noted the benefit of assessing flu vaccine status each year because of the seasonality of the virus and increased opportunity to track patient reasons for opting out. Widespread variation in performance was noted across regions and states. For example, performance rates in Florida and South Dakota were 39 percent and 59 percent, respectively.

The Committee agreed that the measure met the reliability and validity criteria. BONNIE testing was conducted for 25 data elements in one EHR system at two academic medical centers. The Committee raised a concern about the limited number of test sites. The developer noted difficulties recruiting sites to participate in feasibility testing without incentives. One Committee member questioned why this measure was not considered for the Trial Approval Program because it has not been tested extensively. NQF confirmed that eMeasures are eligible for the program if they do not have sufficient testing and have not been implemented. This measure has been implemented, however, and is in Meaningful Use 2 and the Physician Quality Reporting System (PQRS). While the claims-based counterpart, NQF #0041, was previously reviewed by NQF, this measure was never reviewed by NQF. Ultimately, the Committee agreed that the measure met the NQF criteria and recommended NQF #3070 for endorsement.

3086 Population Level HIV Viral Load Suppression (Centers for Disease Control and Prevention): Endorsed

Description: Percentage of persons > 13 years of age with diagnosed HIV infection who are virally suppressed in the measurement year; **Measure Type:** Intermediate Clinical Outcome; **Level of Analysis:** Population: State; **Setting of Care:** Other; **Data Source:** Other

NQF #3086 is a new intermediate clinical outcome measure that assesses the percentage of persons greater than 13 years of age with diagnosed HIV infection who are virally suppressed in the measurement year; it is intended to measure state performance in achieving viral load suppression in people living with HIV. The developer noted that viral load suppression is a good barometer of whether the individual needs of people living with HIV are met and a good indicator of transmission, and therefore, addresses an important public health issue; it is supported by recommendations from the Panel on Antiretroviral Guidelines for Adults and Adolescents and the World Health Organization (WHO),

with systematic review and grading of evidence. One Committee member questioned the necessity of this performance measure to collect state-level surveillance data, and the developer noted that 33 states and the District of Columbia are measuring and reporting viral load suppression among people living with HIV. Performance ranged from 29.4 percent in Arkansas to 64.1 percent in Washington state. The Committee agreed that this measure met the Evidence and Performance Gap subcriteria.

For reliability testing, the developer cited state law and quality control for its data and did not provide any empirical testing at the score- or data element-levels. The developer questioned whether NQF's evaluation criteria can be appropriately applied to surveillance measures. NQF staff confirmed past and continued endorsement of similar surveillance measures, including measures developed by the CDC. It was also noted that, during the technical assistance phase of the project, NQF recommended that the developer assess state audit data and related inputs, where available, to determine reliability and validity; literature or information directly from states was suggested. Committee members recommended that the developer identify the "gold standard"—a data audit of viral load captured in the CDC surveillance system against state records. Ultimately, the Committee failed to reach consensus on the Reliability and Validity criteria. Currently, the data are collected and reported at the state level via the National HIV Surveillance System. For 2012, the developer indicated that 33 states provided complete data; the number is expected to rise to more than 40 in the next year or two. This measure is currently used for CDC state progress reports, Public Health/Disease Surveillance, and to monitor progress towards the National HIV/AIDS Strategy. The Committee had no concerns with either the Feasibility or Usability criteria. The Committee did not vote on an overall endorsement recommendation for NQF #3086 at the in-person meeting because consensus was not reached on Reliability and Validity. Following the in-person meeting, the developer submitted data from an article (Dixon, 2013) that addresses data element-level validity (may be used for reliability under the NQF algorithm) of states' data (electronic lab data then transmitted to CDC) as compared to the gold standard of the patient's medical record.¹² The developer also provided data from three published articles and unpublished data to address potential validity issues of data from multiple sources (depending on the system, some states have e-lab reporting or manual entry or a mix); duplicate counting; and construct validity, examining surveillance data as compared to measures derived from the medical record (Sabharwal, 2014) or a medical record abstraction project that CDC supports in Georgia.¹³ The Committee agreed that the new information provided on testing addressed its concerns. The measure was ultimately recommended for endorsement.^d

Measure Approved for Inactive Endorsement with Reserve Status

1659 Influenza Immunization (Telligen/Centers for Medicare & Medicaid Services): Approved for Inactive Endorsement with Reserve Status

Description: Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to

^d On the post-comment call, the number of Committee members who participated was n=14, but participation varied and, for a few votes, quorum (n=12) was not maintained. Under these circumstances, the decision was made that Committee members who were not present for all votes would be provided a summary of the discussions and be asked to vote on those items for which they had not been present—thus ensuring that for each voting item n=14. It was emphasized that none of the vote tallies on the call were final.

discharge if indicated; **Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Hospital/Acute Care Facility; **Data Source:** Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records

This process measure, first endorsed in 2012, focuses on influenza vaccine status in patients discharged from the hospital between October 1st and March 31st. NQF #1659 is based on recommendations from the CDC's Advisory Committee on Immunization Practices, and the 2012 NQF Committee voted the measure as high for quantity, quality, and consistency ratings of evidence; this Committee agreed to accept the previous discussion. The Committee questioned whether a performance gap existed. The developer reported 10 percent of hospital cases were not vaccinated for the 2014-2015 flu season and slight disparities by race and ethnicity. The Committee ultimately failed the measure on the must-pass subcriterion of Performance Gap, but elected to continue discussing the measure for possible Endorsement with Reserve Status.

Beta binomial signal-to-noise reliability testing at the score level was conducted; the average reliability score was 0.97. Empirical validity testing at the data element was performed; the result from the data extraction was 97.52 percent agreement. The Committee expressed concerns about reliability and validity going forward because of the change from ICD-9 to ICD-10. Specifically, ICD-9 had a specific code for influenza vaccination; ICD-10 has two general immunization codes for hospital settings. Influenza vaccination can be gleaned from CPT codes; however, these codes are not used in hospital admissions. During the Feasibility discussion, it was noted the measure is currently collected via chart abstraction, although the developer noted plans to re-specify it as an eMeasure; no other Feasibility issues were raised. The measure is currently used in several public reporting and payment programs, including Hospital Compare, Annual Payment Update, The Joint Commission Accreditation, Quality Net Benchmarks of Care; no concerns with Usability and Use were raised. The Committee recommended NQF #1659 for inactive endorsement with reserve status.

Measures Approved for Trial Use

3059 One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk (PCPI): Approved for Trial Use

Description: Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945-1965 who received one-time screening for hepatitis C virus (HCV) infection; **Measure Type:** Process; **Level of Analysis:** Clinician: Group/Practice, Clinician: Individual; **Setting of Care:** Ambulatory Care: Clinician Office/Clinic, Home Health, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility, Other; **Data Source:** Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record

NQF #3059 is a new process measure submitted for consideration under the Trial Use program. It focuses on one-time Hepatitis C virus (HCV) screening for patients 18 years and older who have one of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, or birthdate in the years 1945-1965. Evidence presented included guidelines from the American Association for the Study of Liver Diseases (AASLD) and the Infectious Disease Society of America (IDSA), which recommend that "persons should be screened for risk factors for HCV

infection, and one-time testing should be performed for all persons with behaviors, exposures, and conditions associated with an increased risk of HCV infection” and for persons born between 1945 and 1965 without prior ascertainment of risk and high risk individuals and. The developer presented test results from a simulated data set demonstrating that the measure logic can be interpreted precisely and unambiguously (BONNIE testing); testing included data from three separate EHRs that encompassed approximately 27,000 patients; results demonstrated that the logic works correctly and that the appropriate measure is calculated. The developer indicated that the reliability and validity testing required for endorsement will be forthcoming when sufficient data are available to evaluate. Committee members extensively discussed this screening measure in the context of the high cost of HCV treatment strategies, which Medicaid and facilities serving low-income, vulnerable populations cannot afford. The developer noted that even under the most restrictive Medicaid reimbursement criteria, HCV-infected people should qualify for treatment. The developer did not provide specifics on potential uses of the measures, but stated that CMS intends to include the HCV measures in proposed rules, where appropriate. The Committee recommended NQF #3059 for the Trial Use program.

3060 Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users (PCPI): Approved for Trial Use

Description: Percentage of patients, regardless of age, who are active injection drug users who received screening for HCV infection within the 12 month reporting period; **Measure Type:** Process ; **Level of Analysis:** Clinician: Group/Practice, Clinician: Individual; **Setting of Care:** Ambulatory Care: Clinician Office/Clinic, Home Health, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility, Other; **Data Source:** Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record

NQF #3060 is a new process measure focused on screening for Hepatitis C virus among active injection drug users regardless of age. This eMeasure is eligible for the Trial Use program. The developer presented guidelines from the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD and ISDA) that recommend annual HCV testing for persons who inject drugs and for HIV-seropositive men who have unprotected sex with men. Periodic testing should be offered to other persons with ongoing risk factors for exposure to HCV. The developer cited data from the literature that show that 72 percent of persons with a history of injection-drug use are infected with HCV, and remain unaware of their infection status.

The measure specifications use existing value sets when possible and new value sets that have been vetted through Value Set Authority Center (VSAC), with the exception of a couple of value sets which were not in a structured form within one of the EHRs used. Committee members questioned the sensitivity and specificity of identifying intravenous drug users (IVDUs) from medical records. When the measure returns with testing data, the Committee suggested that the developer not only include IVDU data from the social history, but also information from recent emergency department visits, hospitalization, and other healthcare resource uses associated with overdose, treatment, referrals, etc. The developer did not provide specifics on potential uses of the measures, but stated that CMS intends to include the HCV measures in proposed rules, where appropriate. The Committee recommended NQF #3060 for the Trial Use program.

3061 Appropriate Screening Follow-Up for Patients Identified with Hepatitis C Virus (HCV) Infection (PCPI): Approved for Trial Use

Description: Percentage of patients aged 18 years and older with either (1) a positive HCV antibody test result and a positive HCV RNA test result 1or (2) a positive HCV antibody test result and an absent HCV RNA test result who are prescribed treatment or are referred to evaluation or treatment services;

Measure Type: Process ; **Level of Analysis:** Clinician: Group/Practice, Clinician: Individual; **Setting of Care:** Ambulatory Care: Clinician Office/Clinic, Home Health, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility, Other; **Data Source:** Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record

NQF #3061 is a newly submitted process measure that assesses the prescription of treatment or referral to evaluation or treatment services for patients aged 18 years or older who have either (1) a positive HCV antibody test result and a HCV RNA test result or (2) a positive HCV antibody test result and an absent HCV RNA test result. The CDC recommends that “[p]ersons who test positive for both HCV antibody and HCV RNA should be informed that they have HCV infection and need further medical evaluation for liver disease, ongoing medical monitoring, and possible treatment.” According to the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD and ISDA), in the United States, only an estimated 13 percent to 18 percent of HCV-infected persons received treatment as of 2013. Data from the literature show that only 63-77 percent of people who have tested positive for HCV antibodies received follow-up hepatitis care. Key factors influencing physicians’ decision to treat patients with HCV include patient comorbidities, access to care, and treatment tolerance for patients who are infected with HCV.

The measure specifications are consistent with the evidence. The specifications use existing value sets when possible and new value sets that have been vetted through VSAC, with the exception of a couple of value sets of relatively common data elements that were not in a structured form within one of the EHRs used. The Committee noted gaps between referral and treatment and the challenges of assessing follow-up and meaningful adequacy. The developer is conducting a cohort study in four sites and working with referral data within health system databases to assess linkages to HCV care and treatment. While the feasibility analysis meets the requirements for the eMeasure Trial Use program, variability in the structured/nonstructured elements may signal a concern with implementation. The developer did not provide specifics on potential uses of the measure, but stated that CMS intends to include the HCV measure in proposed rules, where appropriate. The Committee recommended NQF #3061 for the Trial Use program.

Measures Not Endorsed

3067 Human Immunodeficiency Virus (HIV) Infection Screening (Centers for Disease Control and Prevention): Not Endorsed

Description: Percentage of patients 15-65 years of age who were tested at least once for HIV; **Measure Type:** Process; **Level of Analysis:** Facility, Clinician: Group/Practice; **Setting of Care:** Ambulatory Care: Clinician Office/Clinic; **Data Source:** Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry

This new measure assesses the percentage of patients 15-65 years of age who were tested at least once for HIV. It is based on a 2013 USPSTF guideline (Grade A) that recommends clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. USPSTF found no direct evidence on the effects of screening versus no screening on clinical outcomes. The Committee asked whether the measure captures patients who are screened, diagnosed, and referred to timely, appropriate care. The developer cited surveillance data that show approximately 70 percent of HIV infected patients receive care within three months of diagnosis. However, the developer also noted the difficulty of assessing these linkages, especially referral documentation in EHRs. The developer also mentioned unsuccessful uptake of measures that assess retention in care. The Committee raised concerns with the age range on both the lower and upper limits, noting that the CDC recommends screening begin at age 13; additionally, HIV rates are increasing in older populations. The Committee also discussed the challenges of adequately assessing screening for adolescents, especially those related to confidentiality and the unintended consequence of disclosing screening to their parents through insurance claims.

Several Committee members questioned how “evidence of HIV infection” in the numerator can be substantiated without testing. The developer noted that this was included to capture patients with HIV who were tested or screened at some point. The developer stated it is willing to remove this data element from the numerator and denominator to minimize confusion. National gap information is not yet available for this new measure; however, testing at five community health centers (CHC) found a range of 20.6-31.1 percent. Results for a fifth CHC with a significant high-risk pool were 65.3 percent, and there are significant disparities in testing rates by race, ranging from a high of 66.2 percent of African Americans to a low of 38.1 percent of Caucasians reporting ever being tested for HIV. The Committee agreed a performance gap exists for this measure. This is an HQMF-compliant eMeasure, and components in the measure logic are represented using HQMF and QDM formats. The measure submission includes test results from five Chicago-area community health centers that belong to a Health Center Controlled Network and use GE Centricity Practice Solutions (three versions among the five sites) and that demonstrate the measure logic can be interpreted precisely and unambiguously. The developer assessed empirical reliability at the data element level and validity of the measure score. Data element testing used a random sample of 300 charts; 100 patients who met the measure and 200 who did not were pulled for chart review. Score-level testing involved examining performance at the five different CHCs, each of which involved multiple care sites and three versions of the GE Centricity platform, and also involved comparing these score results to other practices with established EHRs (Kaiser Permanente Mid-Atlantic States and the Department of Veterans Affairs). The Committee raised concern about reliability testing of the data elements in the EHR; specifically, it questioned how patients who opt out of testing were handled; limited geographic focus on Chicago; and verification of previous screening or test without self-reporting. The developer confirmed that opt outs are not factored into the measure because screening should be part of standard practice. Finally, the developer acknowledged potential over-testing with this measure, but concluded that the value of testing outweighed the potential risk of over-testing. Some concerns were raised about the inclusion of HIV status in the numerator and the cumulative effect on the measure’s ability to discern meaningful differences in HIV infection screening for accountability purposes. While the Committee was generally supportive of the measure, several concerns were raised about the numerator and denominator. Ultimately, the measure failed the Reliability criterion, and the Committee did not recommend NQF #3067 for endorsement.

3071 Follow-up Referral after Positive Developmental Screen (Pediatric Measurement Center of Excellence [PMCoE]): Not Endorsed

Description: Percentage of patients aged 6 to 36 months who were referred for follow-up care within 7 calendar days of receiving a positive developmental screening result; **Measure Type:** Process; **Level of Analysis:** Clinician: Group/Practice, Clinician: Individual, Integrated Delivery System; **Setting of Care:** Ambulatory Care: Clinician Office/Clinic; **Data Source:** Electronic Clinical Data: Electronic Health Record

This newly submitted process measure assesses the percentage of patients aged six to 36 months who were referred for follow-up care within seven calendar days of receiving a positive developmental screening result. The developer presented 2006 recommendation of the American Academy of Pediatrics (AAP), reaffirmed in 2014. The guideline is based on consensus/expert opinion, which recommends that screening be scheduled for development and medical evaluations as quickly as possible, and professionals should coordinate activities and share findings. However, other cited data, including a 2016 USPSTF systematic review, concluded there is insufficient or inconsistent evidence to recommend for or against routine use of brief, formal screening instruments in primary care to detect speech and language delay in children up to five years of age.

The developer provided performance data from four Chicago primary care network test sites (range 31-100 percent, N=15 charts) and the private pediatrics practice in North Carolina (23 percent, N=12). The developer tested the measure in two cohorts: (1) primary care practice networks for four hospitals in the Chicago Pediatric Quality and Safety Consortium and Ashe Pediatrics, and (2) a private pediatrics practice in North Carolina (N=117 charts, data period of 1/1/13-12/31/14). The developer conducted empirical validity testing at the data element level, which assesses reliability and not validity. Many of the issues that the Committee discussed related to evidence, e.g., proximity of the process to improved patient outcomes, were raised during the validity discussion. Additionally, Committee members raised significant concern with the definition of referral and small sample size for testing. The measure failed Validity and the Committee did not recommend NQF #3071 for endorsement.

3087 Completion of a Malnutrition Screening within 24 hours of Admission (Avalere Health/Academy of Nutrition and Dietetics): Not Endorsed

Description: Completion of a malnutrition screening to determine if a patient is at-risk for malnutrition, within 24 hours of admission to the hospital; **Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Hospital/Acute Care Facility; **Data Source:** Electronic Clinical Data: Electronic Health Record

This new eMeasure assesses the completion of a malnutrition screening within 24 hours of hospital admission to determine if a patient is at risk for malnutrition. This process measure is based on 2011 guidelines from the American Society for Parenteral and Enteral Nutrition (ASPEN) that demonstrate that nutrition risk, identified by nutrition screening, is associated with longer length of hospital stay, complications, and mortality. Committee members raised concern about the burden of screening each hospitalization (patients 18 and older) within 24 hours, regardless of patient risk or condition, as well as whether the screening to treatment link was substantiated by evidence. The developer noted that screening for malnutrition is relatively straightforward and should drive further patient evaluation to determine high risk; the developer also stated that screening tools are sensitive enough to identify those at risk for malnutrition. The Committee also questioned why the specifications do not require screening

with a validated tool, as supported by the evidence. The developer responded that there were challenges with selecting one tool to meet every hospital's needs; it noted, however, that implementation of the measure may help in this regard in the future. The Committee was unable to reach consensus on the Evidence criterion, but did agree there was a performance gap based on information submitted by the developer.

This eMeasure's specifications follow the industry-accepted format for eMeasures (HL7 Health Quality Measures Format [HQMF]) and have been tested with the appropriate elements from the QDM. Generally, the Committee believed that the testing met the Reliability and Validity subcriteria, though it noted that the ability of the specifications to accurately identify patients who do not meet numerator criteria was lower at 79.2 percent. During the validity discussion, however, one Committee member raised concern about the degree of variability in screening practice (i.e., who conducts the screening; how screening is defined) in the absence of a standardized screening tool and process. No concern was raised about the feasibility of NQF #3087. With respect to Usability and Use, the measure is currently used in the Academy of Nutrition & Dietetics and Avalere Health – Malnutrition Quality Improvement Initiative, and the developer is working on plans to include the measure in accountability and public reporting programs. Concern was raised about the potential unintended consequences of endorsing this new, yet-to-be implemented measure, without evidence demonstrating that screening leads to improved quality and outcomes. The developer agreed to update the measure submission with plans for future use by the next maintenance review. The Committee did not vote on an overall recommendation for endorsement for NQF #3087 during the in-person meeting because consensus was not reached on Evidence; this decision was made during the post-comment call.

On the post-comment call, Committee members echoed concerns raised during the in-person meeting on the burden of screening every hospitalized patient (18 years and older) within 24 hours, regardless of patient risk or condition. Committee members continued to question whether the screening to patient outcome link is substantiated by evidence. It was noted that the majority of comments received supported measure #3087, #3088, and #3089, but a Committee member stated that despite the large number of comments, including a few new citations, no new evidence addressing the previous concerns was provided; other Committee members echoed this view. Specifically, it was noted that many of the references included within the comments were part of the original submission or addressed similar findings—i.e., that malnourished patients have increased lengths of stay, increased mortality, and other adverse health outcomes, but the references were not specific to the measures' foci (screening, completion of assessment, care plan). One Committee member noted that many articles looked at malnutrition and length of stay, but opined that these did not seem to be the most relevant endpoints to address for screening and food security. Instead, it was suggested that longer term health and impact on utilization cost are more appropriate. Two Committee members expressed support for the measure's intent. As with its previous evaluation, concerns also were expressed about the denominator and the need for targeting a specific population(s) instead of simply those 18 years and older. For this measure and for NQF #3088 and NQF #3089, concerns also were expressed about the lack of exclusions, especially hospice patients or patients who leave against medical advice.

The developer noted that the measure excludes patients who have a length of stay of shorter than 24 hours. Additionally, the developer stated that the measure focuses on malnutrition screening, which is the first step in the process of addressing malnutrition.

During the call, the vote on Evidence for NQF #3087 did not pass, but the outcome was such that the additional votes of those members who had not yet voted might have meant the measure would pass the criterion. Accordingly, Committee members also voted on Overall Suitability for Endorsement. Ultimately, NQF #3087 was not recommended. The measure did not reach the >60 percent threshold to pass on Evidence (H-0; M-8; L-3; I-3), and failed the vote on Overall Suitability (Y-4; N-10).^e

3088 Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening (Avalere Health/Academy of Nutrition and Dietetics): Not Endorsed

Description: Patients age 65 years and older identified as at-risk for malnutrition based on a malnutrition screening who have a nutrition assessment documented in the medical record within 24 hours of the most recent malnutrition screening; **Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Hospital/Acute Care Facility; **Data Source:** Electronic Clinical Data: Electronic Health Record

This new process eMeasure assesses whether patients age 65 years and older identified as at risk for malnutrition based on a malnutrition screening have a nutrition assessment documented in the medical record within 24 hours of the most recent malnutrition screening. Evidence for the measure derives from 2011 ASPEN guidelines that recommend nutrition support intervention for patients identified by screening and assessment as at risk for malnutrition or malnourished.^f Committee members debated whether the number of studies in the observation and randomized trials mentioned above were sufficient, and able to discern the risk of bias. Ultimately, the Committee failed to reach consensus on the Evidence criterion. The developer cited literature demonstrating the opportunity for improvement, and the Committee agreed a performance gap exists.

The measure follows the industry-accepted format for eMeasure (HL7 [HQMF]) and has been tested with the appropriate elements from the QDM. Committee members highlighted several of the same concerns raised with NQF #3087, but did not discuss them in any detail; these include the omission of exclusions and, as with screening, the variability of treatment protocols for malnutrition across hospitals. The Committee considered whether to suspend voting on Reliability until the issues on Evidence were resolved. The Committee also expressed concern about the small number of testing sites; ultimately, the Committee decided to proceed with a vote and the measure passed both Reliability and Validity. Specified for use in EHRs, this measure was tested in two hospital EHR systems, and the

^e On the post-comment call, the number of Committee members who participated was n=14, but participation varied and, for a few votes, quorum (n=12) was not maintained. Under these circumstances, the decision was made that Committee members who were not present for all votes would be provided a summary of the discussions and be asked to vote on those items for which they had not been present—thus ensuring that for each voting item n=14. It was emphasized that none of the vote tallies on the call were final.

^f The submission cited the incorrect guideline, which the developer acknowledged during the Committee's discussion. Appendix B identifies the specific correct guideline and Grade E.

measure submission included a feasibility assessment rating the feasibility in three EHRs. As with reliability, the issue of the small number of systems was raised during the Committee’s discussion, but it did pass Feasibility. With respect to Usability and Use, NQF #3088 is currently used in the Academy of Nutrition and Dietetics and Avalere Health – Malnutrition Quality Improvement Initiative, and the developer is working on plans to include the measure in accountability and public reporting programs (CMS and The Joint Commission). The Committee agreed that the measure met the Usability and Use criterion. The Committee did not vote on an overall recommendation for endorsement for NQF #3088 because consensus was not reached on Evidence.

During the post-comment call, Committee members reiterated their previous concerns from the in-person meeting about the quality, quantity, and consistency of the evidence, in particular the evidence cited in the guideline used to support the measure. The developer responded that it had provided additional studies since the guideline’s publication that report on quality improvement efforts and interventions to improve malnutrition, and further noted that no contradictory evidence of risk to patients has been reported—i.e., no reports of a negative impact on patients being assessed for malnutrition. As with NQF #3087, however, the overall sense was that despite the large number of comments, no new information was provided, and the Committee’s previous concerns remained about the lack of evidence specifically supporting the measure focus.

During the call, the vote on Evidence for NQF #3088 did not pass, but the outcome was such that the additional votes of those members who had not yet voted might have meant the measure would pass the criterion. Accordingly, Committee members also voted on Overall Suitability for Endorsement. Ultimately, NQF #3088 was not recommended: It did not reach the >60 percent threshold to pass on Evidence (H-0; M-8; L-0; I-0), and failed the vote on Overall Suitability (Y-5; N-9).^g

3089 Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment (Avalere Health/Academy of Nutrition and Dietetics): Not Endorsed

Description: A nutrition care plan for those patients who are found to be malnourished based on a completed nutrition assessment with findings of malnutrition; **Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Hospital/Acute Care Facility; **Data Source:** Electronic Clinical Data: Electronic Health Record

NQF #3089 is a new process eMeasure that assesses whether a nutrition care plan exists for those patients who are found to be malnourished based on a completed nutrition assessment with findings of malnutrition. The developer presented evidence from 2011 ASPEN guidelines that recommend nutrition support intervention for patients identified by screening and assessment as at risk for malnutrition or malnourishment. The developer also noted that an evidence synthesis prepared for the Agency for Healthcare Research and Quality (AHRQ) found that older African American patients, as well as older Hispanic women, were at a higher risk of malnutrition compared to Caucasian patients. With respect to

^g On the post-comment call, the number of Committee members who participated was n=14, but participation varied and, for a few votes, quorum (n=12) was not maintained. Under these circumstances, the decision was made that Committee members who were not present for all votes would be provided a summary of the discussions and be asked to vote on those items for which they had not been present—thus ensuring that for each voting item n=14. It was emphasized that none of the vote tallies on the call were final.

demonstrating a performance gap, the developer relied on the limited testing and literature. The Committee agreed that the measure met the Evidence and Performance Gap subcriteria.

The measure specifications follow the industry-accepted format for eMeasure (HL7 [HQMF]) and have been tested with the appropriate elements from the QDM; the specifications use existing value sets, are published within the VSAC, and are available for public use; however, Avalere has yet to complete purpose statements for each of its value sets. The measure was tested at two sites using three EHR systems, and results indicate that the measure logic works correctly and is calculating an appropriate metric. The developer assessed reliability at the data element level using inter-rater reliability between chart abstractors in two sites; the Committee agreed with the developer's assessment that the lower kappa scores were most likely due to the small sample size. The developer reported that results from validity testing demonstrated near perfect chance-adjusted agreement rates for the electronically extracted data element (Nutrition Assessment) once the excluded cases were removed from the calculation. Validity of the chart-abstracted data numerator data element (nutrition care plan documented) was less robust. The specificity for the nutrition care plan data element was strong, but the sensitivity suffered due to disagreement between the chart abstractors. The measure passed Reliability, but the Committee did not reach consensus on Validity. Feasibility was tested in three different EHR systems at two hospitals. The Committee had no concerns with Feasibility. With respect to Usability and Use, NQF #3089 is currently used in the Academy of Nutrition and Dietetics and Avalere Health – Malnutrition Quality Improvement Initiative, and the developer is working on plans to include the measure in accountability and public reporting programs (CMS and The Joint Commission); the Committee agreed that it met the Usability and Use criterion. The Committee did not vote on an overall recommendation for endorsement for NQF #3089 because consensus was not reached on Validity.

During the public comment period, the developer and others submitted comments and additional references to encourage the Committee to recommend the measure. On the post-comment call, a few Committee members mentioned that their concerns had been addressed by the AHRQ brief¹⁴ that documented the problem. It also was noted that the Committee's concern about exclusions was perhaps less of an issue on this measure. One Committee member, however, expressed continued concern over the lack of exclusions for patients on hospice, who refused referral, or had complications; it also was noted that a 2008 paper used by the developer to document a performance gap found that patients who received intervention (getting feedings or vitamins) did not have improved clinical outcomes. A Committee member also raised concern about using the EHR to extract the many plan-of-care data components and expressed skepticism about the ability of EHRs to do this. Another Committee member noted, however, that the developer was working to get more information from SNOMED and LOINC standardized formats. One Committee member also recommended that the developer consider combining NQF #3088 and NQF #3089 into a single measure.

In addition to its comments on exclusions made previously, the developer responded that it continues to work toward electronic capture and mapping to standard elements to address the concerns about EHR data capturing the plan of care. It also noted that several EHRs already incorporate the data elements in their systems. The developer also stated that most of the data for the measure testing provided derived from EHR extraction, but did acknowledge the nutrition plan of care involved chart abstraction.

Although a quorum was present for this vote during the call (n=12), the outcome was such that the additional votes of members who had not yet voted might have meant the measure would pass Validity. Accordingly, Committee members also voted on Overall Suitability for Endorsement during the call. Ultimately, #3089 failed Validity because it did not reach the >60 percent threshold (M-8; L-6; I-0). However, because the Committee had voted on Overall Suitability for Endorsement and because that vote was Y-10; N-4, the measure is being advanced as recommended for purposes of NQF member voting and additional discussion by the Consensus Standards Approval Committee (CSAC).

The CSAC met on January 10, 2017, to discuss the Health and Well-Being measures. The CSAC voted not to endorse the measure because the measure had not passed Validity, a must-pass criterion.

3090 Appropriate Documentation of a Malnutrition Diagnosis (Avalere Health/Academy of Nutrition and Dietetics): Not Endorsed

Description: Appropriate documentation of a malnutrition diagnosis for those patients who are found to be malnourished based on a nutrition assessment; **Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Hospital/Acute Care Facility; **Data Source:** Electronic Clinical Data; Electronic Health Record

This newly submitted process measure assesses the appropriate documentation of malnutrition diagnosis. Evidence suggests that patients who are malnourished while hospitalized have an increased risk of complications, readmissions, and longer hospital stays. The Committee raised several issues including an unclear definition of malnutrition, lack of disparities data, and application of the measure to a broader population. The Committee concluded that, while addressing malnutrition is important, there is not sufficient evidence to support the process of documenting the diagnosis to improve outcomes. The measure did not pass Evidence, and the Committee did not recommend NQF #3090 for endorsement. Following the public comment period, the developer submitted a request for reconsideration. Ultimately, the Committee voted against reconsideration (Y-3; N-11).^h The measure remained as not recommended for endorsement.

Comments Received After Committee Evaluation

The 30-day post-evaluation public and member commenting period was open from October 24 through November 22, 2016. During this commenting period, NQF received 170 comments from 11 member organizations and 13 members of the public (both organizations and individuals). The majority of the comments received supported measures that did not reach consensus, specifically the measures relating to malnutrition. Other comments included support for the Committee's recommendations and disagreement with the Committee's measure endorsement recommendations. Measure-specific comments are included in the [Appendix A](#) measure summaries.

^h On the post-comment call, the number of Committee members who participated was n=14, but participation varied and, for a few votes, quorum (n=12) was not maintained. Under these circumstances, the decision was made that Committee members who were not present for all votes would be provided a summary of the discussions and be asked to vote on those items for which they had not been present—thus ensuring that for each voting item n=14. It was emphasized that none of the vote tallies on the call were final.

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- ² Kindig DA, Asada Y, Booske B. A population health framework for setting national and state health goals. *JAMA*, 2008;299(17):2081-2083.
- ³ Bipartisan Policy Center. *Lots to Lose: How America's Health and Obesity Crisis Threatens Our Economic Future*. Washington, DC: Bipartisan Policy Center; 2012.
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- ⁵ Formerly measure 0421.
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Appendix A: Details of Measure Evaluation

Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable; Y=Yes; N=No

Measures Endorsed

0032 Cervical Cancer Screening (CCS)

[Submission](#) | [Specifications](#)

Description: Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every 3 years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Numerator Statement: The number of women who were screened for cervical cancer.

Denominator Statement: Women 24–64 years of age as of the end of the measurement year.

Exclusions: Exclude: Women who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during their medical history through the end of the measurement year.

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **H-1; M-11; L-1; I-0**

Rationale:

- This maintenance measure focuses on cervical cancer screening, which is a secondary prevention that has been shown to improve health outcomes by detecting cervical cancer in its earlier, more treatable stages. It is used in NCQA's HEDIS tool to assess performance on cervical cancer screening.
- The measure is aligned with 2012 U.S. Preventative Services Task Force (USPSTF) clinical practice guidelines that recommend screening for cervical cancer in women aged 21 to 65 years with cytology (Papanicolaou smear or Pap smear) every three years or, for women aged 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and HPV testing every five years. These guidelines are based on a comprehensive meta-analyses.

- USPSTF guidelines for cervical cancer screening have been updated since 2012, however the updates do not impact the evidence base. The Committee accepted the prior evaluation of this criterion without further discussion.
- In 2013, HEDIS measures covered more than 171 million people from 814 HMOs and 352 PPOs. The developer highlighted variation in cervical cancer screening within commercial and non-commercial health plans; approximately one quarter of commercial plan members and a third of Medicaid plan members are not receiving the recommended screenings. The national performance rate for commercial plans from 2012 to 2014 remained almost unchanged, 77% and 75% respectively.
- One Committee member questioned whether the nearly static commercial plan performance rate signals that the measure is “topped out.” The developer noted that wide variation in performance persists across both commercial health and Medicaid plans; in 2014 there was a 14 percentage point difference (68-82%) between commercial plans in the 10th and 90th percentile range, and a 27 percentage point difference (46-73%) among Medicaid plans.
- The developer cited literature on cervical cancer screening and disparities that reveal significant access barriers to regular cervical cancer screening for recent immigrants and women without health insurance. The data also show that Hispanic and African-American women have the highest incidence of cervical cancer, respectively.
- The developer does not collect performance data that are stratified by sociodemographic variables such as race, ethnicity, education, insurance status, income, or language preference; this was a concern that was raised by the Committee during that last maintenance review. The developer noted that individual plans are stratifying those data, but geographic and plan-level variation makes it difficult to incorporate those data into HEDIS in a standardized way. The Committee recommended that the developer work with plans that are collecting this information and include stratified performance data in the next maintenance submission. The developer agreed to include disparities data in the next maintenance submission. Ultimately, the Committee agreed that a performance gap in care remains.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

Specifications

Rationale

- Generally, the Committee believed the measure is clearly specified; however, several Committee members asked the developer for the following clarification:
 - The USPSTF guidelines recommend cervical cancer screening for average risk women, from age 21 through 65, yet the denominator states women ages 24 through 64. The developer confirmed that the measure assesses whether women 21 through 64 years received cervical cancer screening. Furthermore, the denominator is specified to start at age 24 because there's a three- year look back period (or lag period) where NCQA assesses whether a woman had cytology performed between ages 21 through 24; this assessment is done to ensure that women screened prior to 21 years of age are not captured in the measure.
- Other members questioned why high-risk women >65 years were not included in the measure. The developer confirmed that the measure is intended for health plan and Medicaid populations

and not the Medicare population (>65 years). Furthermore, the specifications are aligned with USPSTF recommendation, screening from age 21 to 65. (The USPSTF recommends screening for women age >65 years who have never been screened, do not meet the criteria for adequate prior screening, or for whom the adequacy of prior screening cannot be accurately assessed or documented.) Committee members strongly urged the developer not to neglect the highest risk women, many of whom do not have access to regular cervical cancer screening or may have received abnormal screens in the past. The developer agreed to take the Committee's concern under consideration.

- One Committee member broached the issue of overutilization and unintended consequences. The developer affirmed that data on overuse of cervical cancer screening are not collected for this 21-65 age cohort, but those data are collected for a separate NCQA measure that assesses non-recommended cervical cancer screening in adolescents, ages 16 through 20.
- One Committee member suggested the developer assess the correlation between the HPV vaccine status measure and this measure, and whether receipt of the three HPV vaccines and subsequent refusal of a Pap smear impact performance results.

2a. Reliability: **Previous Reliability Evaluation Accepted**; 2b. Validity: **M-13; L-0; I-0**

Rationale

- For the 2012 submission, the developer conducted beta-binomial testing to assess signal-to-noise, where the signal is the proportion of variability attributable to performance and noise is that attributable to error. The reliability score is 0.7. (A reliability score of 1 implies that all the variability is attributable to real differences in performance, and a score of 0 implies all variability is attributable to measurement error.) The score-level reliability score for commercial plans is 1.00 for commercial plans and 0.99 for Medicaid plans (2014 HEDIS data). Since reliability testing remains unchanged since the last maintenance review, the Committee accepted the prior evaluation of this criterion without further discussion.
- The developer tested the measure for face validity using a panel with expertise in women's health, oncology, family practice, health plans, state Medicaid agencies and research. The experts determined that the measure score is a valid indicator of quality.
- In addition to face validity, the developer indicated empirical validity testing-independent sample t-test-was performed since the last review, where the P-value of an independent sample t-test was compared for commercial plans in the 20th percentile against commercial plans at the 75th percentile. While this assessment was used to demonstrate meaningful differences in performance across health plans, it does not meet NQF's requirements for score-level validation; therefore, the highest eligible rating for Validity is "moderate" based on their validity testing.

3. Feasibility: H-4; M-9; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- This measure is coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), and abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry).
- The only concern the Committee raised is that "some", not all, data elements are in defined fields in electronic sources.

4. Usability and Use: H-0; M-11; L-2; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The measure is used in several public reporting and payment programs, including the Annual State of Health Care Quality; Medicaid Adult Core Set; Physician Quality Reporting System; California's Value Based Pay for Performance Program; NCQA Health Plan Rating; and CMS' EHR Incentive Program (Meaningful Use).
- Performance rates have remained fairly steady across both commercial and Medicaid plans over the past three years.
- Committee members noted that while the measure received support from the Measure Applications Partnership (MAP) in 2015, the MAP also raised concern about potential overuse and encouraged pairing the measure with one that assesses overuse.

5. Related and Competing Measures

- This measure is related to Measure 0579: Annual cervical cancer screening or follow-up in high-risk women.
- The specifications for Measures 0579 and 0032 are not harmonized.
- The developer states the numerator for both measures focuses on women who had cervical cancer screening during the year, however Measure 0579 focuses on a denominator of high-risk patients and is used in a surveillance strategy. This measure is intended to measure cervical cancer screening in the general population.
- The exclusions for both measures are aligned.

Standing Committee Recommendation for Endorsement: Y-13; N-0

6. Public and Member Comment

Comments Received:

- One commenter was in support of the measure being recommended, acknowledging the burden it would have on some providers to collect the data because most screenings are done outside the physician's office.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for continued endorsement

9. Appeals

- No Appeals received.

0038 Childhood Immunization Status (CIS)

[Submission](#) | [Specifications](#)

Description: Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and a combination rate.

Numerator Statement: Children who received the recommended vaccines by their second birthday.

Denominator Statement: Children who turn 2 years of age during the measurement year.

Exclusions: Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data : Registry

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **H-11; M-2; L-0; I-0**; 1d. Composite: **H-3; M-4; L-4; I-1** *Note: Following the meeting, the developer asked to remove the all-10 components from the measure. Following the comment period, the Committee will review comments and vote on overall suitability for endorsement without the composite.*

Rationale:

- Evidence for this composite, maintenance measure is based on the 2011 CDC's ACIP recommendations for individual, recommended childhood immunizations. The developer has updated the evidence to reference the 2015 ACIP recommendations; the developer states the measure remains aligned with the recommendations.
- The CDC's vaccine-specific recommendations indicate the ACIP recommendations summarize the quality, quantity, and consistency of evidence; however, there is no specific evidence for combing the 10 individual measures into 1 measure.
- Ultimately, the Committee agreed to accept the prior evaluation for the Evidence criterion.
- The developer provided rates for each of the 10 immunizations and the combined rate for all 10. For the combination rate, the developer reports:
 - Commercial: Mean = 47.57% and Minimum-Maximum Range = 0.92-77.31% (2014); 44.84% and 1.95-75.49% (2013); 34.15% and 0.52-74.06% (2012)
 - Medicaid: Mean = 36.1% and Minimum-Maximum Range = 1.7-76.1% (2014); 34.7% and 2.1-76.1% (2013); 31.4% and 1.4%-66.4% (2012)

- The developer does not collect data stratified by race, ethnicity, or language; however, the developer cites literature related to disparities and childhood immunizations:
 - Data from the National Immunization Survey showed that, while disparities in coverage were not observed for most racial/ethnic groups, disparities were seen for children of lower socioeconomic status.
 - Specifically, children living with families with incomes below the federal poverty level had lower coverage than those at or above the poverty level for Dtap, Hib, PCV, HeA, and rotavirus. The differences in rates ranged from 6.0 percentage points (HepA) to 9.5 percentage points (rotavirus).
- The Committee stressed the importance of assessing disparities in order to provide targeted solutions in at risk communities. The developer agreed to include disparities data in the next maintenance submission. Ultimately, the Committee concluded that performance gaps in care remain.
- The measure encompasses rates for 10 individual vaccines and an all-or-nothing composite rate.
- The developer conducted analyses to determine which vaccines to combine, but did not provide an explicit rationale for the composite. The developer implies that it can be inferred based on the ACIP recommendations for the individual childhood immunizations.
- Committee members stressed the importance of assessing individual components to identify meaningful performance gaps.
- The developer explained that performance rates on each vaccine and a combined rate (not only for the 10 measures included in this measure) are reported nationally to allow health plans some degree of flexibility with benchmarking and reporting for various programs.
- One Committee member asked for the number of providers that opt out of the measure. The developer explained that the measure is intended for health plans participating in HEDIS; opt outs and refusals are not specified as exclusions. Through regional reporting, the developer is able to assess geographic trends related to refusals/opt outs.
- Ultimately, the Committee failed to reach consensus on the Composite Quality Construct and Rationale.
- Following the in-person meeting, the developer withdrew the component of the specifications that pertained to the all-10 composite following the in-person meeting.
- During the post-comment call, Committee members noted that since the part of the specification in the question had been removed, the measure was no longer controversial.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **Previous Reliability Evaluation Accepted**; 2b. Validity: **Previous Validity Evaluation Accepted**; 2d. Composite: **H-3; M-7; L-3; I-0**

Rationale:

- The beta-binomial method was used to assess signal-to-noise, where the signal is the proportion of variability attributable to performance and noise is that attributable to error.
- A reliability score of 1 implies that all the variability is attributable to real differences in performance, and a score of 0 implies all variability is attributable to measurement error. The developer states a reliability score of 0.7 is considered "very good."
- Using the 2014 HEDIS dataset, the reliability statistics for receipt of all 10 vaccines was 0.98 for commercial plans and 0.96 for Medicaid plans.

- The reliability statistics for individual vaccine rates (again, using 2014 HEDIS data) were 0.89 to 0.98 for commercial plans and 0.89 to 0.96 for Medicaid plans.
 - The previous NQF Committee concluded reliability was high, with reliability statistics of 0.84 to 0.98; these are directionally the same as the updated reliability testing. The Committee, therefore, accepted the prior Reliability evaluation without further discussion.
 - For the original face validity testing, the developer used a panel of stakeholders, including representatives from women's health, oncology, family practitioners, health plans, state Medicaid agencies, and researchers.
 - The face validity assessment concluded that the measure score was an indicator of quality.
 - The previous NQF Committee concluded validity was moderate. The Committee, therefore, accepted the prior Validity evaluation without further discussion.
 - The developer inadvertently included results of t-test empirical testing to support validity testing. The developer confirmed that these results should be considered under 2b5.
- Meaningful Differences
- Committee members suggested the developer conduct correlation analyses between the composite and each individual measure to increase transparency of the performance scores.
 - There was considerable discussion on whether face validity on the individual measures would satisfy the 2d. criterion; however, NQF noted this testing appropriately supports the Validity criterion.
 - The Committee noted that this large scale composite measure (based on health plans) could signal quality and performance issues in the broader community.

3. Feasibility: H-4; M-9; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The developer notes the following:
 - The measure is coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims);
 - The measure is abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry); and
- Some data elements are in defined fields in electronic sources.

4. Usability and Use: H-12; M-1; L-0; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The measure is used in several public reporting and payment programs, including:
 - NCQA Health Plan Rating
 - NCQA Annual State of Health Care Quality:
 - CMS Medicaid Child Core Set
 - CMS Health Insurance Marketplaces - Quality Rating System
 - CMS Physician Quality Reporting System
 - California's Value Based Pay for Performance Program

- The developer reports that during the last five years, performance has improved. Across commercial plans, the proportion of children documented as having received all 10 vaccines moved from less than a fourth to about half; for Medicaid, the proportion moved from 15% to a little over a third.
 - The 2014 rates of 47.6% for commercial plans and 36.1% for Medicaid plans show large room for improvement.
 - Receipt of some individual vaccines is high, while several others remain low. Across commercial plans in 2014, rates for individual vaccines ranged from an average high of 90.7% for HiB vaccine to a low of 65.1% for influenza vaccine. A similar pattern was seen in Medicaid, with average performance on some vaccines being high, but others being quite low. For Medicaid plans in 2014, receipt of individual vaccines ranged from a high of 90.0% for MMR and VZV vaccine to a low of 51.1% for influenza vaccine.
 - Large differences between lower and higher performing plans exists. For example, in 2014, the average rate of receipt of all vaccines was 28.4% among commercial plans in the 10th percentile and 63.2% among those in the 90th percentile. For Medicaid, the range was 23.4% to 49.6%.
-

5. Related and Competing Measures

- 0041: Preventive Care and Screening: Influenza Immunization (PCPI)
 - 0475: Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge (CDC)
 - 0479: Birth dose of hepatitis B vaccine and hepatitis B immune globulin for newborns of hepatitis B surface antigen (HBsAg) positive mothers (Asian Liver Center at Stanford University)
 - 1659: Influenza Immunization (CMS)
 - 0226: Influenza Immunization in the ESRD Population (KCQA)
-

Standing Committee Recommendation for Endorsement: Y-14; N-0

- During the post comment call, the Committee re-voted on Overall Suitability and ultimately recommended the measure for endorsement.
-

6. Public and Member Comment

Comments received:

- This measure received one comment expressing general support for the measure for public health reporting purposes.
-

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for continued endorsement
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8. Appeals

- No Appeals received.

0039 Flu Vaccinations for Adults Ages 18 and Older

[Submission](#) | [Specifications](#)

Description: The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure is collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, and commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.

Numerator Statement: This measure is reported as two rates:

Flu Vaccination for Adults age 18-64 – Respondents to the Medicaid or commercial CAHPS survey who report having received an influenza vaccination since July of the previous year.

Flu Vaccination for Adults age 65+ - Respondents to the Medicare CAHPS survey who report having received an influenza vaccination since July of the previous year.

Denominator Statement: Flu Vaccinations for Adults Ages 18-64 – Medicaid and Commercial CAHPS respondents age 18-64

Flu Vaccination for Adults Age 65 and Older – Medicare CAHPS respondents age 65 and older.

Exclusions: N/A

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Ambulatory Care : Clinician Office/Clinic, Home Health, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Pharmacy, Ambulatory Care : Urgent Care

Type of Measure: Process

Data Source: Patient Reported Data/Survey

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-11; M-1; L-1; I-0**; 1b. Performance Gap: **H-11; M-1; L-0; I-0**;

Rationale:

- Evidence suggests influenza vaccinations are the most effective way to prevent severe illness or death resulting from influenza and its complications (CDC 2010). This maintenance measure was updated with the 2015-2016 Advisory Committee on Immunization Practices (ACIP) recommendations for influenza vaccinations.
- The Committee discussed the seasonality of the flu and challenges of aligning the CAHPS measure development cycle with changing guidelines. The developer affirmed updating this measure during NQF's Annual Update process.
- In 2015, HEDIS measures covered 172 million commercial health plan beneficiaries. The developer provides rates for influenza vaccinations for adults ages 18-64 only:
 - Commercial: Mean = 49.2% and Minimum-Maximum Range = 38.2 -59.4% (2014); 49.2% and 38.6-59.3% (2013); 54.6% and 44.9-63.4% (2012)

- Medicaid: Mean = 39.8% and Minimum-Maximum Range = 28.3-50.4% (2014); 39.4% and 29.5-49% (2013)
- While race and ethnicity are captured in the CAHPS survey, the developer currently does not receive those or other data stratified by sociodemographic variables like education, income, or language preference.
- The developer does note that the measure can be stratified by payer type and that the mean score for Medicaid plans is 39.8%. Additionally, the developer refers to the literature that shows that that influenza coverage was 31.5% among adults aged 19-49 years and 47.7% among adults aged 50-67 years. Furthermore, disparities in coverage were observed for most racial and ethnic groups: influenza coverage for whites aged 19 years and older was 47.6% compared to that for blacks was 36.5%, and for Hispanics was 33.2%.
- The Committee stressed the importance of assessing disparities in order to provide targeted solutions in at risk communities. The developer agreed to include disparities data in the next maintenance submission. Ultimately, the Committee concluded that performance gaps in care remain.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

- The developer noted changes to measure specifications:
 - Changed the question wording from "Have you had a flu shot since September 1, YYYY?" to "Have you had either a flu shot or flu spray in the nose since July 1, YYYY?"
 - Expanded the age range from 50-64 to 18-64, to align with ACIP guidelines.
 - Added Medicaid product line to the eligible population.
- Committee members questioned whether the measure captured persons receiving vaccinations outside the traditional clinical setting.
- Committee members noted that no information was provided on the extent of missing data, especially by subpopulations.

2a. Reliability: **Previous Reliability Evaluation Accepted**; 2b. Validity: **H-6; M-7; L-0; I-0**

Rationale:

- For the 2012 submission, the developer conducted empirical testing for reliability at the performance score level, and therefore the measure is eligible for a high rating. Reliability statistics of 0.89 to 0.98, depending on plan type, were noted by the developer. Reliability testing remains unchanged since the last maintenance review; therefore, the Committee accepted the prior evaluation of this criterion without further discussion.
- The developer conducted the following validity testing:
 - Face validity concluded that measure has desirable attributes of a HEDIS measure and is relevant, scientifically sound, and feasible.
 - Construct validity of the measure source compared the correlation of the Medicare Pneumococcal Vaccination Status for Older Adults with the Flu Vaccinations for Adults Ages 65 and Older measure. The results indicate that the measures and this measure were significantly positively correlated (<.0001), with a Pearson Correlation Coefficient of 0.82898.
 - Cognitive testing ensured data element validity of the survey questions. Results show that the term flu vaccination is not "sufficiently inclusive." Respondents were best able to answer one question when the question used separate terms for each method of

influenza vaccination administration. Providing additional information about the different types of influenza vaccination did not help respondents answer the questions.

- The Committee concluded that testing results demonstrate sufficient validity so that meaningful conclusions can be made about quality.

3. Feasibility: H-6; M-7; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The CAHPS survey is conducted by third-party vendors via telephone, mail, email, or mixed protocols.
- One Committee member encouraged the developer to harmonize the multiple modes of data collection (telephone, mail, email, or mixed protocols).
- The developer states that there is concern that moving to an internet-based survey administration will bias results, as older more frail adults may be less likely to complete the survey.
- The Committee raised concern that “some”, not all, data elements are in defined fields in electronic sources.

4. Usability and Use: H-6; M-7; L-0; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The measure is used in several public reporting and payment programs, including NCQA Health Plan Ranking; NCQA Annual State of Health Care Quality; NCQA Quality Compass; NCQA Accreditation and Disease Management Accreditation; CMS Medicaid Adult Core Set; and CMS Medicare Advantage Star Rating.
- Performance rates for the older adult population have remained steady over the past three years, which the developer notes is not unusual for survey-based measures.
- In 2013, MAP reviewed this measure and recommended that it be expanded to include all adults. MAP strongly encouraged NCQA to submit the new specifications to NQF during the annual update process. MAP also recommended that CMS use the most current, expanded version of the measure in the Medicaid Adult Core Set.

5. Related and Competing Measures

- 0041: Preventive Care and Screening: Influenza Immunization
- 0226: Influenza Immunization in the ESRD Population (Facility Level)
- 0227: Influenza Immunization
- 0431: Influenza Vaccination Coverage Among Healthcare Personnel
- 0522: Influenza Immunization Received for Current Flu Season (Home Health)
- 0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

- 0681: Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)
- 1659: Influenza Immunization
- The developer notes that this measure is not completely harmonized with other related measures as it is the only measure collected through patient survey.
- Committee members debated the impact of health plans versus providers on measure results.
- The 2012 NQF Committee suggested a universal measure that incorporates all of the various populations included in the influenza immunization measures.

Standing Committee Recommendation for Endorsement: Y-12; N-1

6. Public and Member Comment

Comments received:

- One commenter opposed the use of influenza measures for their lack of inclusion in the Core Measures Set for Primary Care Medical Homes and Accountable Care Organizations. The commenter stated that the measure is a poor indicator of quality because most providers are not the persons in their facilities who administer the vaccination.

Developer response:

- This measure is specified and tested at the health plan and integrated system level of accountability. Flu shots are provided in a variety of acceptable settings (physician office, pharmacy, retail pop-up clinics, public health, and work-sites) which necessitates a survey-based approach to measurement. The intent of this measure is to assess whether members are getting vaccinated seasonally regardless of the site of vaccination. We expect health plans to ensure all adults 18 years and older receive a flu vaccine. We recognize some patients should not receive the flu vaccine due to medical reasons; however, we anticipate this to be evenly distributed across plans. We also do not expect vaccine shortages to have a significant impact on health plan rates for flu vaccination.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for continued endorsement

8. Appeals

- No Appeals received.

0041 Preventive Care and Screening: Influenza Immunization

[Submission](#) | [Specifications](#)

Description: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

Numerator Statement: Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

Denominator Statement: All patients aged 6 months and older seen for a visit between October 1 and March 31

Exclusions: Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons)

Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons)

Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons)

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Setting of Care: Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Other

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data : Registry

Measure Steward: PCPI Foundation

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-2; M-11; L-0; I-0**; 1b. Performance Gap: **H-11; M-3; L-0; I-0**

Rationale:

- Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Influenza viruses cause disease among persons in all age groups. This maintenance measure is based on the Centers for Disease Control and Prevention (CDC) guidelines and recommendations of the Advisory Committee on Immunization Practices (ACIP). ACIP revised its influenza recommendations in 2010 to include a recommendation that annual vaccination be administered to all persons aged ≥ 6 months. This recommendation is current and has not changed as of 2016.
- Committee members questioned whether the measure has broad application beyond primary care settings. The Developer affirmed that the measure can be used broadly across sub-specialties and care settings. However, performance rates are not broken down by setting (e.g. clinician vs. facility).
- The Committee opted to vote on the Evidence criterion because there were some clarifying questions.
- Several Committee members noted the benefit of asking about the flu vaccine each year because of the seasonality of the virus and increased opportunity to track patient reasons for opting out.
- Committee members noted wide variation in performance across regions and states. For example, performance rates in Florida and South Dakota were 39% and 59%, respectively.
- Adults aged 18 years and older had lower rates of vaccination (43.6%) than children six months - 17 years (59.3%).

- Among people ≥ 6 months, vaccination rates for non-Hispanic whites (48.5%) and Asians (51.0%) were higher than that of non-Hispanic blacks (43.8%), Hispanics (44.3%), and people of other or multiple races (44.3%).
- Ultimately, the Committee agreed that performance gaps in care remain.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

- This measure does not align with the standard specifications for influenza vaccination. Specially,
 - Numerator: Does not include offer/decline
 - Denominator: All ages > 6 months – does not differentiate high risk conditions in patients aged 19-49 years
 - Exclusions: Medical, patient and system reasons are not aligned
 - Timing: Patients seen October 1- March 31 is aligned with the standard specifications, however the measure does not acknowledge earlier availability of the vaccination

2a. Reliability: **H-6; M-8; L-0; I-0**; 2b. Validity: **M-13; L-1; I-0**

Rationale:

- One Committee member questioned the relevance of using ESRD reliability testing data for this clinician-level care setting. The developer explained that original testing submitted in 2012 included ESRD data for inter-rater reliability testing. The updated, submitted data include signal-to-noise ratio analysis conducted using registry data from the Physician Quality Reporting System (PQRS) program for January-December 2014.
- The total number of physicians reporting on this measure in 2014 via the registry is 12,184. Of those, 10,986 physicians had all the required data elements and met the minimum number of quality reporting events (10) for a total of 2,417,193 quality events. There were 2,342,385 patients included in this reliability testing and analysis.
- The developer reports this measure has 0.80 reliability when evaluated at the minimum level of quality reporting events and 0.99 reliability when evaluated at the average number of quality events.
- The Committee agreed that the testing results indicate that reliability at the minimum level of quality reporting events and average number of quality events is strong.
- Face validity was assessed by a nine-member expert panel from the PCPI Measurement Advisory Committee that rated their agreement on whether scores from the measure as specified provided an accurate reflection of quality and can be used to distinguish good and poor quality. All but one of the panelists agreed with the statement.
- The developer notes that documentation of medical reasons, patient reasons, system reasons for not receiving the vaccination are acceptable exclusions. Committee members asked for examples of system reasons, which include: “patient on waiting list”; “not entitled to benefits”; “not done –system reason”; and “vaccine not available”. The developer further explained that “system reasons” are included as exclusions to not unfairly penalize providers for circumstances beyond their control.

3. Feasibility: H-10; M-4; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Data are generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score).
 - Data are coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims).
 - All data elements are in defined fields in a combination of electronic sources.
-

4. Usability and Use: H-11; M-3; L-0; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The measure is currently used in Physician Quality Reporting System (PQRS).
 - The developer reports there have been no identified unintended consequences during testing or since implementation.
 - In 2013, the MAP Clinician recommended the measure be retained in PQRS and included in Physician Compare and Value-Based Payment Modifier Program. MAP stated that, while the measure was a process measure, it promotes alignment between public and private programs and addresses disparities.
-

5. Related and Competing Measures

- 0039: Flu Vaccinations for Adults Ages 18 and Older
 - 0226: Influenza Immunization in the ESRD Population (Facility Level)
 - 0431: Influenza Vaccination Coverage Among Healthcare Personnel
 - 0522: Influenza Immunization Received for Current Flu Season (Home Health)
 - 0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)
 - 0681: Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)
 - 1659: Influenza Immunization
 - With regards to harmonization the developer states that related measures have differing target populations from Measure #0041.
-

Standing Committee Recommendation for Endorsement: Y-14; N-0

6. Public and Member Comment

Comment received:

- One commenter opposed the use of influenza measures for their lack of inclusion in the Core Measures Set for Primary Care Medical Homes and Accountable Care Organizations. The commenter stated that the measure is a poor indicator of quality because most providers are not the persons in their facilities who administer the vaccination.

Developer response:

- This measure is based on the CDC’s Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2016–17 Influenza Season. Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications. Influenza may lead to serious complications and vaccination is the most effective protection against influenza virus infection. However, data indicate that less than half of all eligible individuals receive an influenza vaccination. This measure promotes annual influenza vaccination for all persons aged ≥ six months. The measure assesses whether a patient received the flu vaccine or reports previous receipt of the flu vaccine at any other location or via another provider. The measure does not account for patient counseling to receive the vaccine elsewhere because this does not ensure that the patient receives the vaccination thereby reducing the risk of adverse flu-related outcomes as is the intent of this measure.

Comment received:

- One commenter was concerned about the intended misuse of the measure in value-based payment programs instead of how the developer specified within the submission. This commenter recommended influenza vaccinations be given as soon as locally available to all children and suggested that they would support the development of a seasonal influenza immunization measure specific to pediatric populations, in order to capture the needs of the population.

Developer response:

- This measure is based on the CDC’s Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2016–17 Influenza Season. Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications. The expert work group constructed this measure based primarily on the CDC’s recommendation in addition to data on peak month flu activity. While seasonal influenza may be active year-round, the CDC states that peak flu activity is between October and March (<http://www.cdc.gov/flu/about/season/flu-season.htm>). Additionally, the flu season covered is aligned with other NQF endorsed flu vaccine measure and in alignment with NQF’s National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations. Furthermore, the PCPI aims to develop broad measures in response to current national interest in the parsimonious use of measures to reduce the resource burden on health care providers without compromising the quality of patient care. Finally, regarding the AAP’s concern about the availability of the influenza vaccine, the expert work group raised this issue and opted to include a measure exception when the vaccine is not available so as not to inappropriately penalize a clinician for an issue not within his/her control.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for continued endorsement

8. Appeals

- No Appeals received.

0226 Influenza Immunization in the ESRD Population (Facility Level)

[Submission](#) | [Specifications](#)

Description: Percentage of end stage renal disease (ESRD) patients aged 6 months and older receiving hemodialysis or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31 who either received, were offered and declined, or were determined to have a medical contraindication to the influenza vaccine.

Numerator Statement: Number of patients from the denominator who:

1. received an influenza vaccination,* documented by the provider or reported receipt from another provider by the patient (computed and reported separately);

OR

2. were assessed and offered an influenza vaccination but declined (computed and reported separately);

OR

3. were assessed and determined to have a medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, and/or bone marrow transplant within the past 6 months (<6 months prior to encounters between October 1 and March 31) (computed and reported separately).

*Only inactivated vaccine should be used in the ESRD population.

Denominator Statement: All ESRD patients aged 6 months and older receiving hemodialysis and/or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31.

Exclusions: None.

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Facility

Setting of Care: Dialysis Facility

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records

Measure Steward: Kidney Care Quality Alliance

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **H-5; M-7; L-1; I-0**

Rationale:

- Influenza immunization has been shown to decrease the likelihood of hospitalization, morbidity, and mortality among ESRD patients.
- The 2012 NQF Committee noted high ratings on quantity, quality, and consistency of evidence.
- The developer has updated the information to reflect the 2015-2016 ACIP recommendations.
- The Committee accepted the previous evaluation and updated information, which is directionally the same, without further discussion.

- The developer noted significant performance variation across providers for ESRD patients. The mean score across the 53 dialysis facilities in the prospective cohort study and 1,115 patients was 97.1%, with a range of scores from 78-100%.
- These findings indicate that despite the high overall performance rate, the performance for each individual facility ranged from 78% to 100%. Additionally, due to the significant spread between both the minimum and maximum, the measure shows clinically and practically meaningful differences among measured ESRD facilities.
- The developer also noted that the US Renal Dialysis System (USRDS) 2015 Annual Data Report indicates a steady increase in influenza vaccination rates, however only 71% patients with ESRD received an influenza vaccination in the 2012-2013 flu season. This is below the Healthy People 2020 target of 90%.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-1; M-11; L-1; I-1**; 2b. Validity: **H-0; M-13; L-1; I-0**

Rationale:

- One Committee member questioned why pediatric data were not collected when the specifications include ESRD patients aged six months and older. The developer confirmed that the measure is tested at the data element level, where data of birth is a standard field. Furthermore, the pediatric population is fairly negligible in non-pediatric facilities, with fewer than 10,000 children being treated with ESRD.
- Following the data collection period, audits of 11 of the 53 facilities in the prospective cohort study were performed and pertinent data were re-abstracted from the patients' medical records and compared to information submitted by the facility throughout the pilot to assess the measure's reliability.
- Inter-rater reliability was assessed and summarized using Cohen's Kappa with confidence intervals.
- The Kappa statistic was found to be 0.6568 with a 95% confidence interval of 0.521-0.7926. The developer noted that based on literature, this is "substantial agreement." Additionally, the percent agreement between the auditor and facility abstractors was 98.1%. Both of these values determine that the measure is reliable.
- The measure has empirical testing and demonstrates content validity through face validity that was systematically assessed by experts.
- Per the developer, the measure was deemed appropriate by expert opinion from Kidney Care Partners (KCP) and Kidney Care Quality Alliance (KCQA), expert opinion of the NQF ESRD Technical Advisory Panel Steering Committee, and broad agreement through NQF review and voting process.
- The developer also noted that external validity has been met through the original sampling schema, which is representative of the US dialysis population, so the results can be generalized with confidence.
 - 53 facilities were part of the sample and included a mix of facility types.
- The developer has not updated validity testing since the last maintenance review.

3. Feasibility: H-6; M-8; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The developer reported that this measure is coded by someone other than the person obtaining original information (e.g., DRG, ICD-9 codes on claims), and abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry).
- All data elements are in defined fields in electronic sources.
- The developer noted that CROWNWeb will reduce the burden of data collection and that KCQA is in discussion with CMS regarding CROWNWeb compatibility and the need for system updates to accommodate the measure.

4. Usability and Use: H-9; M-5; L-0; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The measure is planned for use and currently used in several public reporting and payment programs, including:
 - Quality Improvement
 - Internal Quality Improvement by KCQA member dialysis organization(s)
 - ESRD Quality Incentive Program (QIP)
- The 2012 NQF Committee noted the focus of this facility-level measure on a high-risk population with significant risk of infection complications, strong supporting evidence of benefit of immunization and alignment with the standard specifications. The Committee recommended that risk stratification and disparities assessment be included in the next update.
- In 2013, MAP noted that the measure may not address a high-leverage opportunity and recommended looking at the impact of vaccination rates across settings.

5. Related and Competing Measures

- 0039: Flu Vaccinations for Adults Ages 18 and Older
- 0041: Preventive Care and Screening: Influenza Immunization
- 0227: Influenza Immunization
- 0522: Influenza Immunization Received for Current Flu Season (Home Health)
- 0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)
- 0681: Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)
- 1659: Influenza Immunization
- This measure is fully harmonized with NQF's standardized specifications for influenza vaccinations and notes that this measure is specifically for the ESRD population and should be separate for this vulnerable population.

Standing Committee Recommendation for Endorsement: Y-13; N-1

6. Public and Member Comment

Comments received:

- Commenters generally supported the Committee’s decision to recommend this measure for continued endorsement.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for continued endorsement

8. Appeals

- No Appeals received.

0279 Bacterial Pneumonia Admission Rate (PQI 11)

[Submission](#) | [Specifications](#)

Description: Admissions with a principal diagnosis of bacterial pneumonia per 1,000 population, ages 18 years and older. Excludes sickle cell or hemoglobin-S admissions, other indications of immunocompromised state admissions, obstetric admissions, and transfers from other institutions.

Numerator Statement: Discharges, for patients ages 18 years and older, with a principal ICD-9-CM or ICD-10-CM-PCS diagnosis code for bacterial pneumonia.

[NOTE: By definition, discharges with a principal diagnosis of bacterial pneumonia are precluded from an assignment of MDC 14 by grouper software. Thus, obstetric discharges should not be considered in the PQI rate, though the AHRQ QI software does not explicitly exclude obstetric cases.]

Denominator Statement: Population ages 18 years and older in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.

Exclusions: Not applicable.

Adjustment/Stratification: Statistical risk model

The predicted value for each case is computed using a hierarchical model (logistic regression with hospital random effect) and covariates for gender, age (in 5-year age groups). An option model is available that includes percent of households under the federal poverty level as well. Because we cannot individually observe the age and gender of each person in a counties population, we use the age and gender distribution of the county to estimate the number of “cases” in each age*gender group. The reference population used in the regression is the universe of discharges for states that participate in the HCUP State Inpatient Data (SID) for the year 2013 (combined), a database consisting of 40 states, and the U.S. Census data by county. The expected rate is computed as the sum of the predicted value for each case divided by the number of cases for the unit of analysis of interest (i.e., area). The risk adjusted rate is computed using indirect standardization as the observed rate divided by the expected rate, multiplied by the reference population rate.

Level of Analysis: Population: County or City

Setting of Care: Other

Type of Measure: Outcome

Data Source: Administrative claims

Measure Steward: Agency for Healthcare Research and Quality

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **The Evidence rating transferred from current Pulmonary and Critical Care Standing Committee;** 1b. Performance Gap: **H-5; M-9; L-0; I-0**

Rationale:

- This population-level, maintenance measure assesses hospitalization rates for pneumonia in the community. It was recently reviewed by the Pulmonary and Critical Care Standing Committee, but was referred by CSAC to the Health and Well-Being Standing Committee for further review.
- The measure assesses an outcome of care; therefore, a systematic review of the body of evidence is not required.
- The developer provided the following rationale for this outcome measure: Access to high quality care, early intervention, and appropriate pharmaceutical treatment may minimize the likelihood of milder respiratory conditions progressing to pneumonia, reducing the likelihood of hospitalizations. The intent of this Preventive Quality Indicator (PQI) is to assess adequate healthcare resources in the community, assuming a portion of pneumonia cases or hospitalizations can be prevented.
- The developer provided updated evidence related to hospitalization for pneumonia, but the Pulmonary and Critical Care Standing Committee agreed with the developer that the underlying rationale for this outcome measure has not changed since the last NQF endorsement review.
- The Health and Well-Being Standing Committee accepted the Pulmonary and Critical Care Standing Committee's decision to accept the prior evaluation on Evidence without further discussion.
- Data provided by the developer show the average performance rate decreased from 5.20 percent in 2009 to 3.28 percent in 2013.
- The developer provided gap data that demonstrated an improvement from 2009 to 2013 (3.02 per 1,000 population to 2.23 per 1,000 population).
- The developer did not provide disparities data related to race, but noted males, patients over 65 years, patients with the lowest income, and patients living in rural areas have the highest rate.
- The developer noted significant gaps between counties; the variation in pneumonia admission rates across counties was largely correlated with income level. The Health and Well-Being Standing Committee recognized that income level is a strong indicator of access to care.
- Overall, the Health and Well-Being Committee agreed the data demonstrate variations in care.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-7; M-7; L-0; I-0**; 2b. Validity: **M-9; L-5; I-0**

Rationale:

- The developer updated the measure specifications measure by: adding diagnosis codes; removing numerator exclusions (MDC14 and MDC15); and adding exclusion of patients with any diagnosis code or procedure code for Immunocompromised state.
- Signal-to-noise reliability testing at the level of the measure score was conducted using data from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID). The developer reported a signal-to-noise ratio of 0.97.
- Validity testing was conducted with a systematic assessment of face validity by four clinical expert panels involving 73 panelists from 2008-2009. The developer reported the panels indicated the measure was useful.
- Like the Pulmonary and Critical Care Standing Committee, the Health and Well-Being acknowledged complex factors influence the measure.
- The measure is risk adjusted for gender and age only. Committee members debated the appropriateness of risk adjustment for socioeconomic factors like income, which was one of the most significant drivers of pneumonia admissions between counties. The Committee generally believed that risk-adjustment would mask disparities across subpopulations and suggested stratification might be more appropriate. Some Committee members noted that stratification could help highlight differences across states and related policy drivers.
- Some Committee members raised concern about the lack of risk adjustment for disease severity.

3. Feasibility: H-11; M-2; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The Committee agreed the measure is feasible. All data elements are in defined fields in electronic claims. The measure is based on readily available administrative billing and claims data. The AHRQ QI software is publicly available and users have more than 10 years of experience using it.

4. Usability and Use: H-3; M-8; L-3; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- This measure is currently publicly reported and used in accountability programs.
- The developer reports bacterial pneumonia/community-acquired pneumonia hospital admissions have decreased by 87,000 fewer hospitalizations from 2011-2013.
- Similar to the Pulmonary and Critical Care Standing Committee, this Committee's members expressed significant concern about the unintended consequence of off-label use of the measure, meaning, the use of the measure in CMS federal programs at a practice level despite being specified for population-level evaluation. The Committee emphasized such implementation is not appropriate because testing and endorsement review occur at the specified level. At the same time, Committee members acknowledged the value of population-level measures such as this type.

- The Committee recommended NQF identify a portfolio of population-level measures and link those to appropriate drivers and intended uses.
 - Generally, the Health and Well-Being Standing Committee believed that the measure assesses the health system more broadly and not only healthcare.
-

5. Related and Competing Measures

- No related or competing measures identified.
-

Standing Committee Recommendation for Endorsement: Y-12; N-2

6. Public and Member Comment

Comments received:

- One commenter opposed the continued endorsement of this measure due to its lack of adjustment for socioeconomic factors and the unintended consequences to organizations that serve rural and low income populations, noting the measure not being a good indication of physician/community wellness. Additionally, the measure is not included in the Core Measure Set for Accountable Care Organizations/Primary Care Medical Homes.

Developer response:

- AHRQ would like to clarify that this measure is intended to measure area-level access to care and community wellness, rather than the quality of physicians, hospitals or other provider groups. As such, higher rates in communities may reflect poorer health in the community, higher chronic disease burden and lower access to care. We observe disparities in populations with lower socioeconomic status, which simply highlights the need in such communities to improve the health of the population and the resources available to promote health in a community. When used as intended and tested, PQI 11 highlights communities in need rather than penalizing the physicians and hospitals in those areas. Possible mechanisms of community influence on hospitalization rates for pneumonia were discussed in the Health and Well Being Committee meeting and do span beyond the actions of any one physician. These mechanisms influence not only the vulnerability of patients in a population to develop pneumonia (e.g. Low access to vaccination) but also the resulting clinical severity of that pneumonia. AHRQ would like to clarify two additional aspects of PQI 11. The commenter does discuss presentation to the ED, but PQI 11 will capture these encounters only if the patient is then hospitalized. Second, the AHRQ PQI software includes two risk models. The default uses only age and gender of the population, while an optional model adds poverty to the model. As was noted in the NQF Committee on socioeconomic adjustment of quality measures, there are valid reasons to both adjust and not adjust for socioeconomic status. As such, AHRQ provides two models to meet various user needs.
-

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for continued endorsement
-

8. Appeals

- No Appeals received.

0431 Influenza Vaccination Coverage Among Healthcare Personnel

[Submission](#) | [Specifications](#)

Description: Percentage of healthcare personnel (HCP) who receive the influenza vaccination.

Numerator Statement: HCP in the denominator population who during the time from October 1 (or when the vaccine became available) through March 31 of the following year:

(a) received an influenza vaccination administered at the healthcare facility, or reported in writing (paper or electronic) or provided documentation that influenza vaccination was received elsewhere; or

(b) were determined to have a medical contraindication/condition of severe allergic reaction to eggs or to other component(s) of the vaccine, or history of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination; or

(c) declined influenza vaccination; or

(d) persons with unknown vaccination status or who do not otherwise meet any of the definitions of the above-mentioned numerator categories.

Numerators are to be calculated separately for each of the above groups.

Denominator Statement: Number of HCP who are working in the healthcare facility for at least 1 working day between October 1 and March 31 of the following year, regardless of clinical responsibility or patient contact.

Denominators are to be calculated separately for:

(a) Employees: all persons who receive a direct paycheck from the reporting facility (i.e., on the facility's payroll).

(b) Licensed independent practitioners: include physicians (MD, DO), advanced practice nurses, and physician assistants only who are affiliated with the reporting facility who do not receive a direct paycheck from the reporting facility.

(c) Adult students/trainees and volunteers: include all students/trainees and volunteers aged 18 or over who do not receive a direct paycheck from the reporting facility.

Exclusions: None.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility

Setting of Care: Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Management Data, Paper Medical Records, Patient Reported Data/Survey

Measure Steward: Centers for Disease Control and Prevention

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-5; M-9; L-0; I-0**; 1b. Performance Gap: **H-3; M-11; L-0; I-0**

Rationale:

- Increased influenza vaccination coverage among Healthcare personnel (HCP) is expected to result in reduced morbidity and mortality related to influenza virus infection among patients. This maintenance measure is based on 2010 Centers for Disease Control and Prevention guidelines: Prevention and control of influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP), which state: "All HCP and persons in training for health-care professions should be vaccinated annually against influenza. Persons working in health-care settings who should be vaccinated include physicians, nurses, and other workers in both hospital and outpatient-care settings, medical emergency-response workers (e.g., paramedics and emergency medical technicians), employees of nursing home and long-term-care facilities who have contact with patients or residents, and students in these professions who will have contact with patients."
- The developer presented results of four randomized trials that are not conclusive because the primary outcome of mortality used in these studies was nonspecific and was not laboratory-confirmed influenza. However, the developer notes remarkable consistency of the findings on reduced mortality among long-term care residents across these four studies provide evidence of the beneficial effect of vaccinating healthcare personnel.
- Pursuant to NQF's standard specifications for influenza vaccinations, Committee members recommended the developer clearly indicate that scores for persons in the numerator (e.g., number of persons specified in the denominator who received the influenza vaccine, or were assessed and offered but declined the vaccination, or were assessed and determined to have a medical contraindication(s) as specified) be computed and reported separately.
- The developer noted continuing significant performance gaps across types of facilities, personnel and geographic regions. Committee members suggested the developer stratify personnel type by clinical duty and/or patient contact. The developer noted that this analysis is not specified within ACIP recommendations; furthermore, the denominator requires that all measured personnel be physically present in the facility while performing a work duty. Theoretically, personnel that meet this criterion would have the opportunity to come into contact with patients or be in a patient's room.
- The data showed an upward trend for acute care hospitals, but still with remaining opportunity for improvement. The mean performance across different types facilities ranged from 76 to 88 percent and the standard deviation ranged from 15 to 23 percent.
- The developer states that since the measure examines summary vaccination data at the facility level, data on individual differences in vaccination by race, ethnicity, gender, age, or other sociodemographic variables are not available.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-1; M-13; L-0; I-0**; 2b. Validity: **H-3; M-11; L-0; I-0**

Rationale:

- The developer attests that there are no significant changes to the measure specifications since the last maintenance review.

- Inter-rater reliability was assessed via 93 randomly-selected facilities in California, New Mexico, New York City and Pennsylvania to determine agreement with how facility personnel categorized the numerator and denominator.
- Sixty records were selected for the sample population across three personnel types: 20 employees; 20 credentialed non-employees; 20 other non-employees.
- Inter-rater agreement was 88% in the first facility (kappa: 0.82), 94% in the second facility (kappa: 0.89), and 80% in the third facility (kappa: 0.66). The developer explained that the percent numerator disagreement was due to facilities reporting verbal “declined vaccination” rather than unknown status.
- In addition to inter-rater reliability, the developer conducted case studies with a series of vignettes in order to classify HCP in the appropriate numerator or denominator group. While most numerator and denominator elements were correctly identified by the majority of respondent, persistent deferrals or verbal declinations for non-medical reasons were difficult to resolve.
- Committee members noted lack of geographic variation in the testing sample population. Absent from the sample was representation from the Midwest and South.
- One Committee member noted that at least two of the four states recruited for measure testing (New York and California) require HCP be vaccinated or wear a mask; these existing mandates may skew performance results.
- Convergent validity was assessed using a one-way ANOVA, where the developer examined the association between the number of evidence-based strategies used by a healthcare institution to promote influenza vaccination and the institution’s reported vaccination rate among each denominator group of HCP. The developer expected that vaccination rates would be positively correlated with an increasing number of strategies that have been found previously to be associated with higher influenza vaccination coverage among HCP.
- The association between employee vaccination rates and number of strategies used was borderline significant at $p=0.05$; between credentialed non-employee vaccination rates and number of strategies it was significant at $p=0.02$; and between other non-employee vaccination rates and number of strategies used was significant at $p=0.01$.
- Face validity was assessed in 2011 using a modified Delphi technique via a panel of nine experts. The panel reached consensus on the definition of the various HCP type groups.

3. Feasibility: H-2; M-12; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Data are generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score).
- The data are coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims).
- Some data elements are in defined fields in a combination of electronic sources. The developer stated that all data could not be captured because the measure is for healthcare personnel as opposed to patients.
- Committee members inquired about the burden of data collection for facilities since, as the developer noted, HCPs may not be part of electronic medical record system within facilities.

- The developer was unable to quantify the data collection burden but acknowledges challenges for facilities without appropriate electronic records systems.

4. Usability and Use: H-11; M-3; L-0; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The measure is currently used in several programs, including:
 - CMS Hospital Inpatient Quality Reporting (IQR) Program
 - CMS Hospital Outpatient Quality Reporting (OQR) Program
 - CMS Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
 - CMS Long Term Care Hospital Quality Reporting (LTCHQR) Program
 - CMS Ambulatory Surgical Center Quality Reporting (ASCQR) Program
 - CMS End Stage Renal Disease (ESRD) Quality Improvement Program (QIP)
 - CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
 - HRSA Medicare Beneficiary Quality Improvement Program (MBQIP)
 - National Healthcare Safety Network Public Health/Disease Surveillance
 - Joint Commission Regulatory and Accreditation Programs
- In 2013 the MAP did not support including the measure in Value Based Payment (VBP) because more experience with the measure is needed. At that time the MAP asserted that the measure was not ready for a pay-for-performance program. The measure was finalized for OQR and IRF QRP.

5. Related and Competing Measures

- The measure is aligned with the NQF standard specifications for influenza vaccinations. However, as with the standard specifications, the three numerator populations be computed and reported separately.

Standing Committee Recommendation for Endorsement: Y-14; N-0

6. Public and Member Comment

Comments received:

- Both commenters support the Committee's recommendation for continued endorsement. One commenter expressed concerns about the intended use of the measure not being as developer specified in the submission, but for use in value-based payment programs.

Developer response:

- NQF 0431 is based on the National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations published by the National Quality Forum in 2008. In this report, NQF notes that the issue of denominator exclusions for delays in influenza vaccine availability was discussed by its Steering Committee of experts. Ultimately, the Steering Committee did not include an exclusion for delays in influenza vaccine supply in the standard measure specifications because (a) there was no systematic and consistent way to implement this exclusion and (b) influenza vaccine supply issues have become less frequent. The Committee further noted that in the event of a declared shortage of influenza vaccine, all healthcare

providers purchasing the vaccine in question would be affected and a measure with no exclusions could be useful in assessing any differential impact of the delay or shortage on different providers.

The window for influenza vaccination (numerator) as measured by NQF 0431 begins as soon as vaccine for the current influenza season becomes available at the reporting facility and extends through March 31 of the following year. In the event of small or brief delays in vaccine availability, the length of this time window should permit reporting facilities adequate time to vaccinate and report data on vaccination even if the process begins later than usual. In the event of a more substantial or lengthier supply interruption, it is likely that many or most reporting facilities would be affected and that influenza vaccine supply concerns would be taken into account by measurement programs and organizations when scoring the measure for that season.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for continued endorsement

8. Appeals

- No Appeals received.

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

[Submission](#) | [Specifications](#)

Description: The measure reports the percentage of short-stay residents or patients who are assessed and appropriately given the seasonal influenza vaccine during the most recently-completed influenza season. The influenza vaccination season (IVS) is defined as beginning on October 1, or when the vaccine first becomes available*, and ends on March 31 of the following year. This measure is based on the NQF's National Voluntary Standards for Influenza and Pneumococcal Immunizations.

The measure is the aggregate of three separately calculated submeasures to reflect the process by which a resident or patient is assessed and appropriately given the influenza vaccination during the current or most recent influenza season.

The three submeasures are as follows:

- residents or patients who received the influenza vaccine during the most recently completed influenza season, either in the facility/hospital or outside the facility/hospital (NQF #0680a);
- residents or patients who were offered and declined the seasonal influenza vaccine (NQF #0680b);
- residents or patients who were ineligible to receive the seasonal influenza vaccine due to contraindication(s) (e.g., anaphylactic hypersensitivity to eggs or other components of the vaccine, see <http://www.cdc.gov/flu/professionals/vaccination/vax-summary.htm>) (NQF #0680c).

*Note: While the IVS officially begins when the vaccine becomes available, which may be before October 1, the denominator time window for the quality measure and references to the IVS for the

denominator specification is from October 1 to March 31 of the following year. The numerator time window and references to the IVS in the numerator specifications may include patients and residents who are assessed and offered the vaccine before October 1. This is based on how the influenza items were coded by the facility.

The denominator consists of patients or short-stay residents 180 days of age or older on the target date of assessment who were in the facility/hospital for at least one day during the most recently-completed influenza vaccination season (IVS). The measure is based on data from the Minimum Data Set (MDS) assessments of nursing home residents, Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) assessments for Inpatient Rehabilitation Facility (IRF) patients, and the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set Version assessments of LTCH patients.

Data are collected in each of these three settings using standardized items across the three assessment instruments. For the nursing homes, the measure is limited to short-stay residents, identified as residents who have had 100 or fewer days of nursing home care. For the LTCHs, this measure will include all patients, irrespective of a patient's length of stay. For IRFs, this measure includes all Medicare Part A and Part C patients, irrespective of a patient's length of stay.

Numerator Statement: The numerator for the overall measure (NQF #0680) is the number of residents or patients in the denominator sample who, during the numerator time window, meet any one of the following criteria: (1) those who received the seasonal influenza vaccine during the most recently-completed influenza season, either in the facility/hospital or outside the facility/hospital (NQF #0681a); (2) those who were offered and declined the seasonal influenza vaccine (NQF #0681b); or (3) those who were ineligible due to contraindication(s) (NQF #0681c). The numerator time window coincides with the most recently-completed seasonal IVS which begins on October 1 and ends on March 31 of the following year.

Each of the three submeasures numerators described above will be computed and reported separately, alongside the overall numerator calculated as the aggregate of the three submeasure numerators.

Denominator Statement: The denominator consists of patients or short-stay residents 180 days of age and older on the target date of the assessment who were in the facility/hospital for at least one day during the denominator time window. The denominator time window is defined as the most recently-completed IVS, from October 1 to March 31 of the following year. For IRF and LTCH, the QM is based on completed patient stays (have discharge assessments). An IRF or LTCH patient with multiple stays during the denominator time window (IVS) will be included more than once in the QM. If a nursing home resident has more than one episode during the denominator time window only the more recent episode is included in this QM.

Exclusions: Residents or patients whose age is 179 days of less of age on target date of the selected influenza vaccination assessment are excluded. LTCH patients whose expired assessments are completed before April 1, 2016 are excluded. After April 1, 2016 expired patients are no longer excluded from the QM, because the influenza items were added to the LCDS expired assessments. Nursing homes with denominator counts of less than 20 residents and IRFs and LTCHs with less than 20 stays in the sample are excluded from public reporting due to small sample size.

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Facility

Setting of Care: Post Acute/Long Term Care Facility: Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility: Long Term Acute Care Hospital, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility

Type of Measure: Process

Data Source: Electronic Clinical Data

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **H-11; M-3; L-0; I-0**

Rationale:

- Since the 2012 maintenance review, the measure underwent an ad hoc review by three technical experts to evaluate expanding the measure beyond the nursing home setting to include inpatient rehabilitation facilities (IRF) and long-term care hospitals (LTCH).
- The developer presented the most recent guideline recommendations from the CDC Advisory Committee on Immunization Practices (ACIP). The recommendations were recently published in the CDC's *Morbidity and Mortality Weekly Report* (MMWR) in August 2015.
- The developer provided a systematic review and Quantity, Quality, and Consistency of a meta-analysis of influenza vaccination in institutionalized older adults. The meta-analysis included four prospective cohort studies, one prospective study of outbreak studies, five retrospective case-control for outbreak studies, and one retrospective case-control study from 1986 to 2013.
- The Committee recommended the developer add measure scores that will be computed and reported, separately, to minimize confusion and align with NQF's standard specifications for influenza vaccination measures.
- The Committee accepted the prior evaluation on the Evidence criterion without discussion.
- The developer provided the performance rates from CMS on short-stay nursing home residents for influenza vaccination season (IVS) 2013-2014 and 2014-2015, and calculated Spear rank coefficients between facility-level scores on the measure and six socioeconomic variables of the facilities counties.
- For the 2014-2015 IVS, the percent of facilities with a perfect score, where all residents and patients were assessed and vaccinated, were low for nursing homes and LTCHs, and for IRFs were around 13 percent. The between facilities' differences in scores were found to have a small to medium and significant effect on QM scores across the setting.
- The developer found that 10% of IRFs had more than 34% of their patients decline the vaccine, and 10% of nursing homes had more than 42% of their short stay residents decline the vaccine.
- Disparities in nursing home residents' vaccination status were observed more than 10 years ago, and there is continued evidence of disparities in whether post-acute residents and patients are assessed and receive the vaccine.
- Males, whites, and older individuals were more likely to receive the vaccine, and women, blacks, Hispanics, and younger individuals were more likely to decline the vaccine across all of the settings.
- The developer also noted disparities between urban and rural facilities.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-7; M-7; L-0; I-0**; 2b. Validity: **H-9; M-5, L-0; I-0**

Rationale:

- Since the last maintenance review, the developer expanded the population to include IRFs and LTCHs. Electronic clinical data was collected from the following setting-specific data source/collection instruments:
 - NHs: Nursing Home Minimum Data Set 3.0
 - IRFs: Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
 - LTCHs: LTCH Continuity Assessment Record & Evaluation (Care) Data Set
- The developer provided inter-rater reliability results using MDS, where influenza related items were assessed on 94 patients from April 1 to December 31, 2006. The results demonstrated a 13.1% discrepancy rate between the nursing facility assessment and the nurse reviewer.
- Testing was not conducted on the reliability of the influenza measure items from the LTCH Care Data Set or the IRF-PAI. The developer stated that it is reasonable to apply the reliability testing from the MDS to the LTCH CARE Data Set and the IRF-PAI. The developer also noted the populations are not identical and some differences in reliability may exist.
- For all three settings, the developer conducted a confidence interval analysis to examine the proportion of facilities with measure scores that are significantly different from the national facility-level mean. The confidence interval analysis for IRFs found that 66.0% of facilities had significantly different measure scores from the mean. The confidence interval analysis for LTCHs found that that 88.0% of facilities had significantly different measure scores from the mean. The confidence interval analysis for NHs found that that 68.0% of facilities had significantly different measure scores from the mean.
- For performance score testing, the developer refers to the missing data analysis for performance measure score testing, which NQF does not consider an appropriate statistical method for this purpose.
- NQF staff asked for further clarification on the methods and measure results used to assess reliability, given the developer indicated it was inferring item-level reliability for IRFs and LTCHs from MDS (nursing homes) and that it had indicated that the populations are not identical so some differences in reliability may exist.
- Ultimately, the Committee failed to reach consensus on the Reliability criterion.
- The developer did not present data-element validity testing of the influenza-related items in IRF-PAI or the LTCH CARE Data Set v2.0 and stated that previous validity results of the nursing home MDS items are applicable to the IRF-PAI and LTCH CARE Data Set v2.0 items. NQF guidance states that validity testing of data elements typically analyzes agreement with another authoritative source of the same information.
- The developer cited public comments as confirmation of face validity.
- Committee members raised concern about the face validity assessment and asked the developer for more specificity.
- NQF staff noted that face validity of the measure score, as an indicator of quality, may be adequate if accomplished through a systematic and transparent process by identified experts and explicitly addresses whether performance scores resulting from the measure as specified can be used to distinguish good from poor quality.

- The developer noted that the expert panel that assessed face validity was asked about the importance, value of the measure; the impact on processes of care; whether the measure will result in the staff assessing and vaccinating patients or residents; and the unintended consequences and potential burden. The panel also determined that the measure appropriately distinguishes good quality of care from poor care; all but one of the expert panel members voted to maintain this measure.
- Overall, the testing data were difficult for NQF staff and several Committee members to interpret. The developer agreed to work with NQF staff following the in-person meeting to clarify any remaining concerns and misinterpretations of the data.
- Ultimately, the Committee failed to reach consensus on the Validity criterion.
- Following the in-person meeting, NQF worked with the developer to bring forward the additional data for the additional levels of analysis. The developer submitted a detailed explanation of testing methods, and new score-level reliability testing results for the additional care settings, including analyses of variance and confidence interval.
- On the call, the lead discussants from the in-person meeting, as well as other Committee members believed the new data sufficiently addressed their concerns.
- The Committee re-voted and passed this measure on Scientific Acceptability.

3. Feasibility: H-13; M-1; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- All defined elements are in defined fields in a combination of electronic sources; the data are collected from influenza items included in the MDS 3.0 for nursing homes, the IRF-PAI assessment instrument for IRFs, and the LCDS assessment admission and discharge instruments for LTCHs.

4. Usability and Use: H-12; M-2; L-0; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- This measure is used in the following public reporting programs:
 - NH: Nursing Home Quality Reporting Program - Nursing Home Compare website.
 - IRF and LTCH: Inpatient Rehabilitation Facility Quality Reporting Program and LTCH Quality Reporting Program (to begin 2017).
- This measure is used in the following payment program:
 - IRF and LTCH: Inpatient Rehabilitation Facility Quality Reporting Program and LTCH Quality Reporting Program.
- This measure is used for the following quality Improvement with benchmarking (external benchmarking to multiple organizations) purposes:
 - NH: *Healthy People 2020* Goal: Immunization and Infectious Diseases. This measure is included in the Quality Measure Composite Score used in the National Nursing Home Quality Care Collaborative (NNHQCC) led by CMS and the Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs).

- This measure is used for several quality improvement initiatives (Internal to the specific organization):
 - NH: Certification and Survey Provider Enhanced Reports (CASPER) /Centers for Medicare and Medicaid Services.
 - IRF and LTCH: Inpatient Rehabilitation Facility CASPER Provider Reports and LTCH CASPER Provider Reports are planned.
 - The developer noted that the mean performance rates for NHs decreased from 81.6% from the 2013-2014 IVS to 80.6% during the 2014-2015 IVS.
 - Data collection for IRFs and LTCHs started in 2014, therefore performance trends are not available.
 - The developer stated that no published evidence of unintended consequences to the populations was identified, other than the low rate of adverse reaction to the vaccine and potential for being vaccinated more than once. Discomfort from the injection was described by some experts as a potential unintended consequence that may limit activity for a few days. Some experts reported that some short-stay residents and patients did not like being repeatedly offered the vaccine across settings and providers, or being asked about and offered the vaccine when they were experiencing serious health problems. However, the benefits of the influenza vaccine were felt to greatly outweigh these unintended consequences.
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5. Related and Competing Measures

- 0039: Flu Vaccinations for Adults Ages 18 and Older
 - 0226: Influenza Immunization Status for ESRD Population (Facility Level)
 - 0681: Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)
 - 1659: Influenza Immunization
 - The developer stated that the measure for nursing homes was expanded to both additional post-acute care settings (LTCHs and IRFs) and is harmonized with the NQF Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations.
 - Measure #0039 is based on the CAHPS Health Plan Survey and targets a different and non-institutionalized population.
 - Measure #1659 targets a different population in multiple settings and does not include those assessed but not given the vaccine. #1659 has a different target population with a broader numerator (multiple other vaccines).
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Standing Committee Recommendation for Endorsement: Y-14; N-0

6. Public and Member Comment

No comments were received on this measure during public and member comment.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for continued endorsement
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8. Appeals

- No Appeals received.

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

[Submission](#) | [Specifications](#)

Description: This measure reports the percentage of long-stay residents, 180 days of age and older, who were in a nursing facility for at least one day during the most recently completed influenza vaccination season (IVS), and who were assessed and appropriately given the seasonal influenza vaccine. The IVS is defined as beginning on October 1 and ends on March 31 of the following year. The measure is the aggregate of three separately calculated submeasures to reflect the process by which a resident is assessed and appropriately given the influenza vaccination during the current or most recent influenza season.

The three submeasures are as follows:

- resident received the influenza vaccine during the current or most recent influenza season, either in the facility or outside the facility (NQF #0681a);
- resident was offered and declined the seasonal influenza vaccine (NQF #0681b); and
- resident was ineligible to receive the seasonal influenza vaccine due to contraindication(s) (e.g., anaphylactic hypersensitivity to eggs or other components of the vaccine, see <http://www.cdc.gov/flu/professionals/vaccination/vax-summary.htm>) (NQF #0681c).

The denominator consists of long-stay residents 180 days of age or older on the target date of assessment who were in the facility for at least one day during the most recently-completed influenza vaccination season (IVS). This measure is based on data from the Minimum Data Set (MDS 3.0) OBRA, PPS, and/or discharge assessments during the selected influenza season. Long-stay residents are identified as those who have had 101 or more cumulative days of nursing facility care.

A separate measure (NQF #0680, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)) is to be used for residents who have had 100 or fewer cumulative days of nursing facility care.

Numerator Statement: The numerator is the number of long-stay residents with a target assessment (OBRA admission, quarterly, annual or significant change/correction assessments; PPS 5-,14-, 30-, 60-, 90-day, or readmission/return assessments; or discharge assessment with or without return anticipated) who were in the denominator sample, AND who meet any of the following criteria for the selected influenza season: (1) they received the influenza vaccine during the most recent influenza season, either in the facility or outside the facility (NQF #0681a), (2) they were offered and declined the influenza vaccine (NQF #0681b), or (3) they were ineligible due to medical contraindication(s) (NQF #0681c). The influenza season is defined as July 1 of the current year to June 30 of the following year. The IVS begins on October 1 and ends on March 31 of the following year.

Each of the three submeasure numerators described above will be computed and reported separately, alongside the overall numerator calculated as the aggregate of the three submeasure numerators.

Denominator Statement: The denominator is the total number of long-stay residents 180 days of age or older on the target date of the assessment who were in the nursing facility who were in a nursing facility for at least one day during the most recently completed IVS that have an OBRA, PPS, or discharge assessment and who did not meet the exclusion criteria.

Exclusions: Residents whose age is 179 days or less on target date of selected influenza vaccination assessment are excluded.

If the facility sample includes fewer than 30 residents after all other resident-level exclusions are applied, then the facility is excluded from public reporting.

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Facility

Setting of Care: Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility

Type of Measure: Process

Data Source: Electronic Clinical Data

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **H-1; M-13; L-0; I-0**

Rationale:

- Since the 2012 maintenance review, the measure underwent an ad hoc review by three technical experts to evaluate expanding the measure beyond the nursing home setting to include inpatient rehabilitation facilities (IRF) and long-term care hospitals (LTCH).
- The developer presented the most recent guideline recommendations from the CDC Advisory Committee on Immunization Practices (ACIP). The recommendations were recently published in the CDC's *Morbidity and Mortality Weekly Report (MMWR)* in August 2015.
- The developer provided a systematic review and Quantity, Quality, and Consistency of a meta-analysis of influenza vaccination in institutionalized older adults. The meta-analysis included four prospective cohort studies, 1 prospective study of outbreak studies, five retrospective case-control for outbreak studies, and 1 retrospective case-control study from 1986 to 2013.
- The Committee recommended the developer add “measure scores will be computed and reported separately” to minimize confusion and align with NQF’s standard specifications for influenza vaccination measures.
- The Committee accepted the prior evaluation on the Evidence criterion without discussion.
- The developer provided the performance rates from CMS for long-stay nursing home residents for influenza vaccination season (IVS) 2011-2012, 2012-2013, 2013-2014, and calculated Spear rank coefficients between facility-level scores on the measure and six socioeconomic variables of the facilities counties.
- For the 2014-2015 IVS, the percent of facilities with a perfect score, where all residents and patients were assessed and vaccinated, was 20% for nursing homes.
- Disparities in nursing home residents' vaccination status were observed over 10 years ago, and there is continued evidence of disparities in whether post-acute residents and patients are assessed and receive the vaccine.
- Males, whites, and older individuals were more likely to receive the vaccine, and women, blacks, Hispanics, and younger individuals were more likely to decline the vaccine across all of the settings.
- The developer also noted disparities between urban and rural facilities.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-1; M-9; L-2; I-2**; 2b. Validity: **H-1; M-13; L-0; I-0**

Rationale:

- For this maintenance measure, the developer provided inter-rater reliability results using MDS, where influenza related items were assessed on 94 patients from April 1 to December 31, 2006. The results demonstrated a 13.1% discrepancy rate between the nursing facility assessment and the nurse reviewer.
- For measure score reliability testing, the developer conducted a confidence interval analysis to examine the proportion of facilities (stratified by facility size) with measure scores that are significantly different from the national facility-level mean using 2014-2015 IVS MDS 3.0 data. The confidence interval analysis for IRFs found that 61.3% of facilities had significantly different measure scores from the mean. 48.1% of facilities had significantly higher measure scores than the national mean and 13.1% of facilities had significantly lower measure scores than the mean.
- Data-element validity testing was conducted using “gold-standard” nurses trained in the MDS 3.0 instrument from August 2006 to February 2007 and included 19 Veterans Affairs (VA) nursing homes with 754 residents and 71 community nursing facilities with 3,822 residents. The gold-standard nurse trained a facility nurse in the MDS 3.0 instrument. Two MDS items were calculated and then compared, “Influenza vaccine given” and “Reason influenza vaccine not given”. For the “influenza vaccine given” item, the kappa statistics for the gold-standard nurse to gold-standard nurse agreement was 0.989 (n=349), and the kappa for gold-standard nurse to facility nurse agreement was 0.941 (n=900). For the item “reason the vaccine was not given”, the kappa statistic for the gold-standard nurse to gold-standard nurse agreement was 0.976, and the kappa for gold-standard nurse to facility nurse agreement was 0.820.
- Empirical validity testing of the measure score was conducted by assessing the correlation of the performance measure score on this measure and NQF 0680: Percent of Residents or Patients or Patients Assessed and Appropriately Given the Seasonal Influenza Vaccine (short-stay) for the 2014-2015 IVS. It is expected that the quality of care provided by a facility to residents with a nursing home stay of 101 days or more (long-stay), would be of similar quality as the care provided to residents with a nursing home stay of 100 days or less (short-stay) and long-stay residents receiving the pneumococcal vaccine, therefore the respective performance measure scores should be similar. The developer reported an r value of 0.65 (p<0.001) between this measure and the short-stay influenza vaccination measure which means that 65.0% of the total variation in performance on this measure can be explained by variation in performance on the measure for residents with short-stays.

3. Feasibility: H-12; M-2; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- All defined elements are in defined fields in a combination of electronic sources; the data are collected from influenza items included in the MDS 3.0 for nursing homes, the IRF-PAI assessment instrument for IRFs, and the LCDS assessment admission and discharge instruments for LTCHs.

4. Usability and Use: H-11; M-3; L-0; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The measure is in use in the Nursing Home Quality Reporting Program - Nursing Home Compare website.
- The developer noted that the mean quality measure increased from the 2011-2012 IVS (92.6%) to the 2012-2013 IVS (93.6%), and it decreased through the 2014-2015 IVS (93.2%). However, the magnitude of these changes is small, and the developer posited that the decrease in the performance scores may be due to confounding factors rather than performance on the measure.
- The developer stated that no published evidence of unintended consequences to the populations have been identified, other than the low rate of adverse reaction to the vaccine and potential for being vaccinated more than once. Discomfort from the injection was described by some experts as a potential unintended consequence that may limit activity for a few days. Some experts reported that some short-stay residents and patients did not like being repeatedly offered the vaccine across settings and providers, or being asked about and offered the vaccine when they were experiencing serious health problems. However, the benefits of the influenza vaccine were felt to greatly outweigh these unintended consequences.

5. Related and Competing Measures

- 0680: Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)
- 0226: Influenza Immunization in the ESRD Population (Facility Level)
- 0039: Flu Vaccinations for Adults Ages 18 and Older
- 1659: Influenza Immunization
- The developer stated that #0680 applies to short-stay nursing home residents as well as additional post-acute settings (LTCHs and IRFs), and is based on different data sources for each setting. The developer noted that #0680 and #0681 are harmonized with the NQF Voluntary Consensus Standards for Influenza Immunizations and each other to the extent possible.
- Measure 0039 is based on the CAHPS Health Plan Survey and targets a different and non-institutionalized population.
- Measure 1659 targets a different population in multiple settings and does not include those assessed but not given the vaccine; #1659 has a different target population with a broader numerator (multiple other vaccines).

Standing Committee Recommendation for Endorsement: Y-13; N-1

6. Public and Member Comment

No comments were received on this measure during public and member comment.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for continued endorsement

8. Appeals

- No Appeals received.

2828 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

[Submission](#) | [Specifications](#)

Description: Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter

Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30

Age 18 – 64 years BMI ≥ 18.5 and < 25

Numerator Statement: Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.

Denominator Statement: There are two (2) Initial Patient Populations for this measure:

Initial Patient Population 1: All patients 18 through 64 years on the date of the encounter with at least one eligible encounter during the measurement period.

Initial Patient Population 2: All patients 65 years of age and older on the date of the encounter with at least one eligible encounter during the measurement period.

Exclusions: Initial Patient Population 1: Patients who are pregnant or encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate.

Initial Patient Population 2: Encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate.

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Clinician: Group/Practice, Clinician: Individual

Setting of Care: Ambulatory Care: Clinician Office/Clinic

Type of Measure: Process

Data Source: Electronic Clinical Data: Electronic Health Record

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-2; M-10; L-3; I-1**; 1b. Performance Gap: **H-7; M-7; L-1; I-0**

Rationale:

- This new measure is the eMeasure version of measure 3039 (formerly Measure 0421). The information provided for Evidence and Performance Gap is identical to that submitted for 3039. The ratings for Evidence and Performance Gap from Measure 3039 were automatically assigned to this eMeasure without further discussion.
- This measure addresses the importance of BMI measurement and follow-up when the measurement is outside normal parameters.
- More than one-third (34.9%) of adults in the United States are obese. Obesity among adults younger than 65 years has been shown to reduce life expectancy and increase medical costs.
- Only 50 percent of obese adults in 2010 received advice to exercise or perform physical activity.
- Weight loss has been shown to decrease blood pressure, reduce triglycerides and decrease blood glucose levels and hemoglobin A1c, all of which may slow the progression of type 2 diabetes and cardiovascular disease.
- The developer cited clinical practice guideline recommendations for BMI and follow-up from the American College of Cardiology (ACC)/American Heart Association (AHA)/The Obesity Society (TOS) and National Heart, Lung and Blood Institute (NHLBI).
- The measure is intended for all eligible providers, including social workers, psychologists, physical therapists, occupational therapists.
- The developer stated that the measure specifications for a follow-up plan are not prescriptive; the plan does not need to include testing or measurement, like height.
- Some Committee members were skeptical that the measure would be able to influence behavior without a robust follow-up plan, while others believed it is a good first step in assessing performance of BMI and follow-up.
- One Committee member questioned whether the evidence was aligned with current USPSTF guidelines that specifically recommend screening for all adults, but the follow-up plan focuses on the obese population, not overweight.
- Cited literature shows a performance gap among clinicians recommending exercise and physical activity for obese adults.
- While average provider-level performance rates by year are improving, the data suggest there are opportunities for improvement: In 2011, 2.7% of eligible professionals reported BMI rates and follow-up when measurement was outside normal parameters and in 2014, 19.2% of eligible professionals did the same.
- Committee members noted studies that caution against measuring obesity indiscriminately because of physiological differences between racial and ethnic groups that have influence on how obesity is identified. The developer did not find statistical difference in BMI rates between racial and ethnic groups.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-1; M-13; L-1; I-0**; 2b. Validity: First Vote: **M-7; L-8; I-0**; Second Vote: **M-10; L-5; I-0**

Rationale:

- Health Quality Measures Format (HQMF) specifications for this eMeasure were provided with the submission.

- The submitted eMeasure specifications use existing value sets when possible and new value sets that have been vetted through the Value Set Authority Center (VSAC). Each of the value sets has been published and is publicly accessible. However, after a review of the value sets through the VSAC, the Quality Improvement Program (QIP) included the metadata but did not fill out the general purpose statements or include the inclusion/exclusions of the value sets. The new feasibility assessment will require that the measure developer fill out all of this information to constitute a high-quality value set. It is strongly recommended that QIP go back and complete all of this information for the value sets it has published.
- Reliability testing was conducted on the performance score using data collected from three primary care practices. One practice provided data from 10/3/2015 – 12/31/2015; 1 provided data from 1/1/2014 – 12/31/2014; and 1 provided data from 3/28/2015 – 3/26/2016. Combined, the data from these three sites reflect 357 eligible professionals (EPs), each with an average of 190 patients. The three practices provided two types of data from their EHRs: an extract containing patient-level data for all eligible patients, and a manual abstraction of a simple random sample of 104 or 105 patient records from each practice.
- A signal-to-noise analysis using the beta-binomial model was conducted.
- Data element validity was assessed by comparing the results of the EHR extract and manual abstraction for the sample of patients. Clinical reviewers abstracted 314 patient records (104 or 105 from each of three sites) from 66 providers to assess validity of data extracted from the EHR.
- Agreement on the numerator criteria to meet performance is substantial (90.16%, kappa 0.80), as is its inverse on failing performance (89.84%, 0.80).
- Agreement on exclusion from the denominator also is substantial (99.05%), although the limited number of exclusions in the abstracted data set resulted in a lower chance-adjusted kappa statistic (0.40).
- The developer acknowledged implementation barriers, including variability in how BMI outside normal parameters is captured in electronic health record (EHR) systems; some capture these data in structured fields and others in unstructured fields.
- One Committee member raised concern that in most the EHR systems, information about whether a patient is in palliative care is in unconstructed fields and is difficult to capture.

3. Feasibility: H-6; M-6; L-3; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- All data elements are generated by and used by healthcare personnel during the provision of care and are in defined fields in EHRs
- A feasibility assessment is provided with this eMeasure submission.

4. Usability and Use: H-4; M-9; L-2; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The claims based version of this measure (#3039) is currently reported in Physician Quality Reporting System (PQRS). According to the 2014 PQRS Reporting Experience, in 2014, Measure

#3039 was 1 of the top five reported measures within PQRS; 105,261 EPs (19.2% of all eligible entities) reported the measure.

- Measure #3039 is also reported in the Medicare and Medicaid EHR Incentive Programs (commonly referred to, collectively, as the Meaningful Use program). At this time, no publicly available data are available on the frequency with which this measure is reported as part of the Meaningful Use Program.

5. Related and Competing Measures

- #3039: Preventive Care and Screening: Body Mass Index Screening and Follow-up Plan
- #0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- #1349: Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)
- #2601: Body Mass Index Screening and Follow-Up for People with Serious Mental Illness

Standing Committee Recommendation for Endorsement: Y-14; N-1

6. Public and Member Comment

No comments were received on this measure during public and member comment.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for endorsement

8. Appeals

- No Appeals received.

3039 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

[Submission](#) | [Specifications](#)

Description: Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter

Normal Parameters:

Age 65 years and older BMI ≥ 23 and < 30 kg/m²

Age 18–64 years BMI ≥ 18.5 and < 25 kg/m²

Numerator Statement: Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.

Denominator Statement: All patients aged 18 years and older

Exclusions: Not Eligible for BMI Calculation or Follow-Up Plan – A patient is not eligible if one or more of the following reasons are documented:

Patient is receiving palliative care

Patient is pregnant

Patient refuses BMI measurement (refuses height and/or weight)

Any other reason documented in the medical record by the provider why BMI calculation or follow-up plan was not appropriate

Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Clinician: Group/Practice, Clinician: Individual

Setting of Care: Ambulatory Care: Clinician Office/Clinic

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data: Registry

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-2; M-10; L-3; I-1**; 1b. Performance Gap: **H-8; M-8; L-0; I-0**

Rationale:

- This maintenance measure (formerly Measure 0421) is the claims-based version of eMeasure 2828. The information provided for Evidence and Performance Gap is identical to that submitted for 2828. The ratings for Evidence and Performance Gap were automatically assigned to Measure 2828 without further discussion.
- This measure addresses the importance of body mass index (BMI) measurement and follow-up when the measurement is outside normal parameters.
- More than one-third (34.9%) of adults in the United States are obese. Obesity among adults younger than 65 has been shown to reduce life expectancy and increase medical costs.
- Only 50 percent of obese adults in 2010 received advice to exercise or perform physical activity.
- Weight loss has been shown to decrease blood pressure, reduce triglycerides, and decrease blood glucose levels and hemoglobin A1c, all of which may slow the progression of type 2 diabetes and cardiovascular disease.
- The developer cites clinical practice guideline recommendations for BMI and follow-up from the American College of Cardiology (ACC)/American Heart Association (AHA)/The Obesity Society (TOS) and National Heart, Lung and Blood Institute (NHLBI).
- The measure is intended for all eligible providers, including social workers, psychologists, physical therapists, occupational therapists.
- The developer stated that the measure specifications for a follow-up plan are not prescriptive; the plan does not need to include testing or measurement, like height.
- Some Committee members were skeptical that the measure would be able to influence behavior without a robust follow-up plan, while others believed it is a good first step in assessing performance of BMI and follow-up.

- One Committee member questioned whether the evidence was aligned with current USPSTF guidelines, which specifically recommend screening for all adults, but the follow-up plan focuses on the obese population, not overweight.
- Cited literature shows a performance gap among clinicians recommending exercise and physical activity for obese adults.
- While average provider-level performance rates by year are improving, the data suggest there are opportunities for improvement: In 2011, 2.7% of eligible professionals reported BMI rates and follow-up when measurement was outside normal parameters and in 2014, 19.2% of eligible professionals did the same.
- Committee members noted studies that caution against measuring obesity indiscriminately because of physiological differences between racial and ethnic groups that have influence on how obesity is identified. The developer did not find statistical differences in BMI rates between racial and ethnic groups.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-10; M-6; L-0; I-0**; 2b. Validity: **M-12; L-4; I-0**

Rationale:

- Reliability testing was conducted on the performance score using Medicare Part B claims and PQRS registry data at the individual clinician level.
- The claims data used for testing included encounters between 1/1/2014 and 12/31/2014 reported by 67,715 providers, with an average of 170 patients in the denominator per provider.
- The registry data included encounters between 1/1/2014 and 12/31/2014 reported by 19,087 providers through PQRS, with an average of 211 cases in the denominator per provider.
- A signal-to-noise analysis using the beta-binomial model was conducted. The average reliability scores are 0.97 for both claims and registry reported data.
- Face validity was conducted by a group of nine clinicians eligible to report the measure.
- 6 of the nine experts polled agree or strongly agree that the measure provides an accurate reflection of quality.

3. Feasibility: H-4; M-11; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The developer stated that all data elements are in defined fields in a combination of electronic sources. The developer also stated that given past experience with this measure's use in current CMS quality reporting programs, providers find the measure feasible to report.
- The developer acknowledged implementation barriers, including variability in how the BMI outside normal parameters is captured across electronic health record (EHR) vendors; some capture these data in structured fields and others in unstructured fields.

4. Usability and Use: H-7; M-8; L-1; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- This measure is currently reported in Physician Quality Reporting System (PQRS). According to the 2014 PQRS Reporting Experience, in 2014, this measure was 1 of the top five reported measures within PQRS; 105,261 EPs (19.2% of all eligible entities) reported the measure.

5. Related and Competing Measures

- #0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- #1349: Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)
- #2601: Body Mass Index Screening and Follow-Up for People with Serious Mental Illness

Standing Committee Recommendation for Endorsement: Y-15; N-1

Rationale

- The Committee recommended that by the next maintenance review, the developer re-specify requirements for the follow-up plan to include intervention strategies like motivational interviewing or gym referrals, for example, which have a strong link to improved patient outcomes.
- The Committee also recommended that the developer better align the evidence with the USPSTF's current guidelines related to the appropriate referral population (obese vs. overweight).

6. Public and Member Comment

No comments were received on this measure during public and member comment.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

8. Appeals

- No Appeals received.

3070 Preventive Care and Screening: Influenza Immunization

[Submission](#) | [Specifications](#)

Description: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

Numerator Statement: Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

Denominator Statement: All patients aged 6 months and older seen for a visit between October 1 and March 31

Exclusions: Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons)

Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons)

Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons)

Adjustment/Stratification: No risk adjustment or risk stratification.

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician: Group/Practice, Clinician: Individual

Setting of Care: Ambulatory Care: Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility, Other

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record

Measure Steward: PCPI Foundation

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: Accepted vote from Measure 0041 **H-2; M-11; L-0; I-0**; 1b. Performance Gap: **H-10; M-4; L-0; I-0**

Rationale:

- This is the eMeasure version of the claims-based Measure #0041, Preventive Care and Screening: Influenza Immunization. Therefore, the vote and discussion from Measure #0041 applies to this new measure:
 - Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Influenza viruses cause disease among persons in all age groups. This maintenance measure is based on the Centers for Disease Control and Prevention (CDC) guidelines and recommendations of the Advisory Committee on Immunization Practices (ACIP). ACIP revised its influenza recommendations in 2010 to include a recommendation that annual vaccination be administered to all persons aged ≥ 6 months. This recommendation is current and has not changed as of 2016.
 - Committee members questioned whether the measure has broad application beyond primary care settings. The developer affirmed that the measure can be used broadly across sub-specialties and care settings. However, performance rates are not broken down by setting (e.g. clinician vs. facility).
 - Several Committee members noted the benefit of asking about the flu vaccine each year because of the seasonality of the virus and increased opportunity to track patient reasons for opting out.

- Committee members noted wide variation in performance across regions and states. For example, performance rates in Florida and South Dakota were 39% and 59%, respectively.
- Adults aged 18 years and older had lower rates of vaccination (43.6%) than children six months - 17 years (59.3%).
- Among people ≥ 6 months, vaccination rates for non-Hispanic whites (48.5%) and Asians (51.0%) were higher than that of non-Hispanic blacks (43.8%), Hispanics (44.3%), and people of other or multiple races (44.3%).
- Ultimately, the Committee agreed that performance gaps in care remain.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-8; M-5; L-0; I-0**; 2b. Validity: **M-11; L-2; I-0**

Rationale:

- This measure does not align with the standard specifications for influenza vaccination. Specially,
 - Numerator: Does not include offer/decline
 - Denominator: All ages > 6 months - does not differentiate high risk conditions in patients aged 19-49 years
 - Exclusions: Medical, patient and system reasons are not aligned
 - Timing: Patients seen October 1- March 31 is aligned with the standard specifications, however the measure does not acknowledge earlier availability of the vaccination
- The submitted eMeasure specifications follow the industry accepted format for eMeasure (HL7 Health Quality Measures Format (HQMF)).
- All components in the measure logic of the submitted eMeasure are represented using the HQMF 2.0 and the elements map to the most recent version of the QDM.
- The submitted eMeasure specifications use existing value sets when possible and new value sets that have been vetted through the Value Set Authority Center (VSAC). The developer also used standard code sets from both ICD-10-CM and SNOMED-CT.
- The submission includes test results from a simulated data set demonstrating the measure logic can be interpreted precisely and unambiguously. Testing was conducted in three facilities; the developer was able to check compliance from a large PQRS data set that came from multiple EHR vendors. The developer also used BONNIE on a simulated test cohort of 52 patients to ensure the logic calculated correctly.
- The beta-binomial method was used to assess signal-to-noise, where the signal is the proportion of variability attributable to performance and noise is that attributable to error. Signal to noise ratio analysis was conducted using registry data from the PQRS program for the time period January 2014 through December 2014.
- The total number of physicians reporting on this measure, via the registry option, in 2014, is 12,184. Of those, 10,986 physicians had all the required data elements and met the minimum number of quality reporting events (10) for a total of 2,417,193 quality events. There were 2,342,385 patients included in this reliability testing and analysis. These were the patients that were associated with physicians who had 10 or more patients eligible for this measure and remained after exceptions were removed.
- The developer reports this measure has 0.80 reliability when evaluated at the minimum level of quality reporting events and 0.99 reliability when evaluated at the average number of quality events.

- The developer states that the results indicate that reliability at the minimum level of quality reporting events is high and reliability at the average number of quality events is very high.
 - The developer reports the measure logic performs as expected in the BONNIE system.
-

3. Feasibility: H-2; M-10; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The submission contains a feasibility assessment that addresses data element feasibility and follow-up; the measure developer indicates that the measure logic is feasible based on EHR vendors' assessments. Given that the measure has been used in Meaningful Use 2 (MU2) and in PQRS successfully, there are few issues with feasibility. Although exceptions and exemptions are not in a structured form, it is not difficult to retrieve these from the notes section because electronic immunization reporting has been implemented for some time.
 - BONNIE testing was also conducted for the eMeasure using two academic medical centers and an EHR vendor on 35 elements.
 - The Committee raised concern that the feasibility testing was conducted in only two academic medical facilities. The developer noted difficulties recruiting sites to participating in feasibility testing, because they do not incentivize potential participants.
 - One Committee member questioned why this measure was not considered for the Trial Approval Program because it has not been tested extensively. NQF confirmed that eMeasures are eligible for the Program, if they do not have sufficient testing and have not been implemented. This measure has been implemented and is part of Meaningful Use 2; however, while the claims-based counterpart, Measure #0041, was previously-reviewed by NQF, this measure was never reviewed by NQF.
 - The developer is continuing to recruit and identify test sites, and test, and will make every effort to test this eMeasure in another EHR system and setting by the next Annual Update.
-

4. Usability and Use: H-3; M-11; L-0; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- This measure is currently part of Meaningful Use Stage 2 (EHR Incentive Program).
 - The claims based version of this measure (0041) is currently used in Physician Quality Reporting System (PQRS).
 - The developer did not provide information on the performance of this measure in Meaningful Use.
 - The developer only provided information on the performance of 0041 in PQRS. The average performance rates on Preventive Care and Screening: Influenza Immunization over the last several years are as follows: 2011: 50.4%; 2012: 43.9%; 2013: 46.8%; 2014: 46.3%. These rates reflect a gradual, yet slow improvement.
-

5. Related and Competing Measures

- 0039: Flu Vaccinations for Adults Ages 18 and Older

- 0226: Influenza Immunization in the ESRD Population (Facility Level)
- 0431: Influenza Vaccination Coverage Among Healthcare Personnel
- 0522: Influenza Immunization Received for Current Flu Season (Home Health)
- 0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)
- 0681: Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)
- 1659: Influenza Immunization

Standing Committee Recommendation for Endorsement: Y-14; N-0

6. Public and Member Comment

Comments received:

- One commenter opposed the use of influenza measures for their lack of inclusion in the Core Measures Set for Primary Care Medical Homes and Accountable Care Organizations. The commenter stated that the measure is a poor indicator of quality because most providers are not the persons in their facilities who administer the vaccination.
- One commenter was concerned about the intended misuse of the measure in value-based payment programs instead of how the developer specified within the submission. This commenter recommended influenza vaccinations be given as soon as locally available to all children and suggested that they would support the development of a seasonal influenza immunization measure specific to pediatric populations, in order to capture the needs of the population.

Developer response:

- This measure is based on the CDC’s Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2016–17 Influenza Season. Routine annual influenza vaccination is recommended for all persons aged ≥ 6 months who do not have contraindications. The expert work group constructed this measure based primarily on the CDC’s recommendation in addition to data on peak month flu activity. While seasonal influenza may be active year-round, the CDC states that peak flu activity is between October and March (<http://www.cdc.gov/flu/about/season/flu-season.htm>). Additionally, the flu season covered is aligned with other NQF endorsed flu vaccine measure and in alignment with NQF’s National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations. Furthermore, the PCPI aims to develop broad measures in response to current national interest in the parsimonious use of measures to reduce the resource burden on health care providers without compromising the quality of patient care. Finally, regarding the AAP’s concern about the availability of the influenza vaccine, the expert work group raised this issue and opted to include a measure exception when the vaccine is not available so as not to inappropriately penalize a clinician for an issue not within his/her control. Influenza may lead to serious complications and vaccination is the most effective protection against influenza virus infection. However, data indicate that less than half of all eligible individuals receive an influenza vaccination. This measure promotes annual influenza vaccination for all persons aged \geq six months. The measure assesses whether a patient received the flu vaccine or reports previous receipt of the

flu vaccine at any other location or via another provider. The measure does not account for patient counseling to receive the vaccine elsewhere because this does not ensure that the patient receives the vaccination thereby reducing the risk of adverse flu-related outcomes as is the intent of this measure.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for endorsement

8. Appeals

- No Appeals received.

3086 Population Level HIV Viral Load Suppression

[Submission](#) | [Specifications](#)

Description: Percentage of persons > 13 years of age with diagnosed HIV infection who are virally suppressed in the measurement year.

Numerator Statement: Number of HIV-diagnosed persons, aged ≥13 years and alive at the end of the measurement year, whose most recent viral load test showed that HIV viral load was suppressed

Denominator Statement: Number of persons ≥ 13 years with HIV infection diagnosed by previous year and alive at year end.

Exclusions: Definition excludes persons with HIV diagnosed during the measurement year and persons no longer alive at the end of measurement year.

Adjustment/Stratification: No risk adjustment or risk stratification.

For current measure application at sub-national level, data are stratified by jurisdiction of residence (for 2012, 27 states and the District of Columbia).

National data are typically also stratified and presented by sex/gender, transmission risk category, age, and race/ethnicity (specific variables and code sets in case form supplied in appendix--results available in tables 5a/5b of appended report, cdc-hiv-surveillancereport_vol20_no2). States with complete viral load (VL) reporting can also conduct such stratification locally, but these data are not required for current public reporting activities.

Level of Analysis: Population: State

Setting of Care: Other

Type of Measure: Intermediate Clinical Outcome

Data Source: Other

Measure Steward: Centers for Disease Control and Prevention

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-5; M-10; L-0; I-0**; 1b. Performance Gap: **H-10; M-5; L-0; I-0**

Rationale:

- This new measure is intended to assess state performance in achieving viral load suppression among people living with HIV.
- The developer notes that viral load suppression is a good barometer of whether individual needs of people living with HIV are met and a good indicator of transmission, and therefore, addresses an important public health issue from the individual patient perspective.
- The developer indicated the measure is supported by clinical practice guideline recommendations from the Panel on Antiretroviral Guidelines for Adults and Adolescents and the World Health Organization (WHO), with systematic review and grading of evidence.
- Committee members asked why the lower age limit (13 years) was not aligned with the guidelines (15 years). The developer explained that the measure is based on CDC's surveillance systems, which assess pediatric HIV/AIDS separately from adult HIV/AIDS.
- One Committee member questioned the necessity of this performance measure to collect state-level surveillance and who is being measured.
- Committee members also acknowledged that this performance measure could also be used by state Medicaid programs and CMMI's state innovation models (SIM) to drive improvement in this area of measurement.
- The developer explained that states are already collecting these data to drive improvement in viral load suppression rates for people living with HIV.
- The developer noted that 33 states and the District of Columbia (DC) are measuring and reporting viral load suppression among people living with HIV to their state surveillance program. (At the time of measure submission, the developer indicated that 27 states were measuring and reporting viral load suppression rates.) For the remaining states, there is growing momentum to enact laws that mandate reporting or ensure quality assurance and standardization, and consistency, where these data are already collected and calculated.
- Of persons aged >13 years with diagnosed HIV infection by year-end 2011 and alive at year-end 2012 in the measured states and DC, 265,644 had a suppressed viral load. These 265,644 persons represented 50.1% of the total number of persons aged >13 years with HIV infection diagnosed by year-end 2011 and alive at year-end 2012.
- From the data provided, the range of percentages of patients with a suppressed viral load, was 29.4% in Arkansas to 64.1% in Washington state.
- One Committee member raised concern about the lag time of CDC surveillance reporting (typically 2-3 years) and suggested interim reporting.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **M-11; L-3; I-0; I-3**; 2b. Validity: **H-1; M-13; L-0; I-0**

Rationale:

- This is a new intermediate outcome measure that is specified at the state level of analysis.
- For reliability testing, the developer cited state law and quality control for its data and did not provide any empirical testing at the data element level.
- The developer questioned whether NQF's evaluation criteria can be appropriately applied to surveillance measures. NQF staff confirmed past and continued endorsement of similar surveillance measures, including measures developed by the CDC. Furthermore, during the

technical assistance phase of the project, NQF recommended the developer assess state audit data and related inputs, where available, to determine reliability and validity.

- To meet NQF’s requirements for testing,¹ Committee member suggested the developer identify the “gold standard” – data audit of viral load captured in the CDC surveillance system against state records. The developer feared this may increase state data collection burden.
- To further inform NQF’s evaluation of public health surveillance measures,¹ Committee member recommended NQF review the CDC’s surveillance measure evaluation guidance that focuses more on public health rather than clinical standards.
- Ultimately, the Committee failed to reach consensus on the Reliability and Validity criterions.
- Prior to the post-comment call, the developer presented data from an article (Dixon, 2013)¹ that addressed the data element-level validity (may be used for reliability under the NQF algorithm) of states’ data (electronic lab data then transmitted to CDC) as compared to the gold standard of the patient’s medical record. CDC also presented data from three published articles and unpublished data to address potential validity issues of data from multiple sources (recall that, depending on the system, some states have e-lab reporting or manual entry or a mix); duplicate counting; and construct validity examining surveillance data as compared to measures derived from the medical record (Subharwal, 2014) or a medical record abstraction project CDC supports in Georgia.²
- During the post-comment call, one Committee member raised questions about the benefit of a state-level quality measure, especially given that the CDC can collect the data without the measure and the measure will not be used for accountability. Another Committee member felt it would aid in standardization of care across states, particularly in states where there are less resources in the Department of Health.
- One Committee member noted the measure provided a population health perspective, not about individual clinical management, so that states, cities, and other bodies submitting the information can improve their process of care more broadly—which may include providing better access to care for patients, identifying patients and bringing them into the care system, and ensuring good management at the population level as well as the clinical level. NQF staff advised that NQF is seeking broader quality measurement that spans into the population realm.
- Finally, a Committee member expressed concern over possible misuse of the measure—while it is being endorsed at the population measure, there are several examples of these types of NQF-endorsed measures now being used at facility and clinician leaves. NQF noted the endorsement is intended to be specific to the level submitted by the developer, but recognized that “off label” use if of concern and does not dispute the high stakes. Staff stated it will continue to emphasize the endorsed level of analysis for this measure.
- The developer spoke in support of the measure, agreeing with the argument that the measure will give states support at the individual and state level more broadly as well as get patients into care.
- Ultimately, the measure passed on the Reliability and Validity criteria.

3. Feasibility: H-5; M-8; L-2; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The developer presented calculations based on case and laboratory reports entered in the HIV Surveillance System. Laboratory data reports contain viral load test results ordered by providers

as part of care. The required data elements are generally available in electronic health records or other electronic sources.

- The data have been collected and reported at the state level via the National HIV Surveillance System. For 2012, the developer indicated 33 states provide complete data, and it expected the number of states completing these data to rise to more than 40 within the next year or two.
- The developer explained that the absence of viral load suppression rates on state progress reports has incentivized several states to push for legislation that mandates reporting and to build infrastructure to support it.

4. Usability and Use: H-4; M-10; L-1; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- This measure is currently used for CDC state progress reports, Public Health/Disease Surveillance and to monitor progress towards the National HIV/AIDS Strategy.
- In 2014, the MAP supported this measure for the Medicare and Medicaid EHR Incentive Program for Eligible Professionals since it addresses a measure type not adequately represented in the program measure set. MAP did not support this measure for the Physician Compare and VBPM Programs since it prefers outcome measures for these programs.
- In 2015, MAP did not encourage this measure for further consideration for MSSP. MAP recommended that this be part of a composite measure for specific conditions for MSSP.
- NQF notes that the measure is specified at the population level, however, the MAP recommendations are for levels of analyses not intended by the developer.

5. Related and Competing Measures

- 2082: HIV viral load suppression (HRSA): Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.
- The level of analysis for the HRSA measure is clinician. Furthermore, it does not specify age of over 13 years; and it indicates the measure target population is all patients with HIV diagnosis, regardless of age.

Standing Committee Recommendation for Endorsement: Y-13; N-1

6. Public and Member Comment

Comments received:

- This measure received three identical comments from one organization in general support of the measure. The comment cites the potential for enhanced standardization of care across states, health care programs and insurance plans, reducing disparities in clinical outcomes. Additionally, the comment mentions the potential for improved public health and surveillance as a result of the measures endorsement.

Committee response:

- The Committee agreed the new information provided in the comment on testing addressed its concerns. These concerns specifically focused on the benefit of a state-level quality measure,

especially given that the CDC can collect standardized data across states which will aid in surveillance and patient access to care. Additionally, the Committee expressed concern over possible misuse of the measure—while the measure is being endorsed at the population level, there are several examples of these types of NQF-endorsed measures now being used at facility and clinician levels.

NQF Response:

- NQF notes that endorsement is intended to be specific to the level stated by the developer at the time of submission, but recognize that “off label” use is of concern and does not dispute the high stakes. Staff will continue to emphasize the endorsed level of analysis for this measure.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for endorsement

8. Appeals

- No Appeals received.

Measure Approved for Inactive Endorsement with Reserve Status

1659 Influenza Immunization

[Submission](#) | [Specifications](#)

Description: Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.

Numerator Statement: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated.

Denominator Statement: Acute care hospitalized inpatients age 6 months and older discharged during the months of October, November, December, January, February or March.

Exclusions: The following patients are excluded from the denominator:

- Patients less than 6 months of age
- Patients who expire prior to hospital discharge
- Patients with an organ transplant during the current hospitalization (Appendix_A.Table 12.10 Organ Transplant codes.xls)
- Patients for whom vaccination was indicated, but supply had not been received by the hospital due to problems with vaccine production or distribution
- Patients who have a Length of Stay greater than 120 days
- Patients who are transferred or discharged to another acute care hospital
- Patients who leave Against Medical Advice (AMA)

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records

Measure Steward: Centers for Medicare and Medicaid Services

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **H-0; M-7; L-7; I-0**; Second Vote: **H-0; M-5; L-9; I-0**

Rationale:

- This maintenance measure is based on recommendations from the Advisory Committee on Immunization Practices (ACIP).
- The 2012 NQF Committee voted high for Quantity, Quality, and Consistency ratings of evidence, which included a Cochrane review of 51 studies.

- The developer updated this submission to reflect 2015-2016 ACIP recommendations; the developer states the measure remains aligned with the recommendations.
- The Committee accepted the prior evaluation on Evidence without further discussion.
- The Committee noted marginal gaps in overall performance, where for the 2014-2015 flu season, 10% of hospital cases were not vaccinated.
- The developer explained that the sample population was a little more than 1.5 million cases; out of those, about 92,000 were not screened and/or vaccinated. If extrapolated to the larger population of patients discharged from hospitals during that time, a little more than a million patients were not screened and/or vaccinated.
- The developer noted slight disparities in care between racial and ethnic groups; specifically, Hispanic patients have lower vaccination rates than non-Hispanics (91% vs 95%). However, American Indian or Alaska Native (83.97%) are less likely than those identified as White (94.76%) to be screened and vaccinated.
- The Committee acknowledged the importance of this hospital-based measure, but did not believe the narrowing performance gaps were clinically significant.
- The Committee opted to proceed with the Inactive with Reserve Status pathway, and recommended that clinical practice and behavior be periodically monitored.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-7; M-2; L-4; I-1**; 2b. Validity: **M-11; L-3; I-0**

Rationale:

- Performance score reliability was calculated to distinguish differences between the performances of different facilities. The testing calculated signal-to-noise ratio for each facility meeting the minimum case count.
- Reliability was estimated using the beta-binomial model. The developer noted that reliability scores vary from 0.0 to 1.0. A score of zero implies that all variation is attributed to measurement error (noise or the individual accountable entity variance) whereas a reliability of 1.0 implies that all variation is caused by a real difference in performance (across accountable entities).
- Results were provided from Hospital Compare during the October 1, 2014-March 31, 2015 data collection period. Reliability scores range from 0.33 to 1.00, with an average reliability score of 0.97. The developer stated that this indicates that the measure is able to identify differences in performance between individual facilities.
- Embedded in ICD-9 was a specific code for influenza vaccination. Committee members raised concern about the two, general immunization codes for hospital settings that are embedded in ICD-10 and the subsequent impact on reliability and validity of the measure. Influenza vaccination can be gleaned from CPT codes, however, these codes are not used in hospital admissions.
- Empirical validity testing was assessed at the data element level via the CDAC validation method. Abstractors pulled the same data elements from each chart that the hospital abstracted when originally submitting data. Results were compared and cases and data elements where there were mismatches were identified.
- For the 2014-2015 influenza season, a total of 5,285 cases were used for validation. The two data elements abstracted were IMM-2, Discharge Disposition and Influenza Vaccination Status.

- For the discharge disposition data element, 5,284 records were validated, showing 131 abstraction mismatches, representing a 97.52% agreement.
- For the influenza immunization status data element, 4,875 records were validated, showing 475 abstraction mismatches, representing 90.26% agreement.
- The developer stated that the results show a high degree of agreement before hospital abstraction and CDAC validation abstraction for both data elements.

3. Feasibility: H-2; M-8; L-4; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- This measure is currently chart-abstracted, however, the developer noted plans to re-specify it as and eMeasure.
- Some data elements are in defined fields in electronic sources.
- The developer noted that this measure is coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), and abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry).
- The Committee discussed the potential burden of manual chart abstraction in the absence of an ICD-10 code that indicates screened and/or vaccinated.
- The developer noted hospitals are collecting these data via screening forms upon admission, which has minimized the data collection burden.

4. Usability and Use: H-9; M-5; L-0; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- This measure is used in several public reporting and payment programs, including:
 - Hospital Compare
 - Annual Payment Update
 - The Joint Commission Accreditation
 - QualityNet Benchmarks of Care
- Several Committee members had difficulty assessing this measure for usability and use in light of the relatively few opportunities for improvement.

5. Related and Competing Measures

- 0038: Childhood Immunization Status (CIS)
- 0039: Flu Vaccinations for Adults Ages 18 and Older
- 0041: Preventive Care and Screening: Influenza Immunization
- 0226: Influenza Immunization in the ESRD Population (Facility Level)
- 0431: Influenza Vaccination Coverage Among Healthcare Personnel
- 0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

- 0681: Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

Standing Committee Recommendation for Inactive Endorsement with Reserve Status: Y-14; N-0

6. Public and Member Comment

No comments were received on this measure during public and member comment.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision: Approved for inactive endorsement with reserve status**

8. Appeals

- No Appeals received.

Measures Approved for Trial Use

3059 One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk

[Submission](#) | [Specifications](#)

Description: Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945–1965 who received one-time screening for hepatitis C virus (HCV) infection

Numerator Statement: Patients who received one-time screening for HCV infection

Denominator Statement: All patients aged 18 years and older who were seen twice for any visit or who had at least one preventive visit within the 12 month reporting period with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945–1965

Exclusions: Denominator Exclusions:

Patients with a diagnosis of chronic hepatitis C

Denominator Exceptions:

Documentation of medical reason(s) for not receiving one-time screening for HCV infection (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons)

Documentation of patient reason(s) for not receiving one-time screening for HCV infection (eg, patient declined, other patient reasons)

Adjustment/Stratification: No risk adjustment or risk stratification.

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician: Group/Practice, Clinician: Individual

Setting of Care: Ambulatory Care: Clinician Office/Clinic, Home Health, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility, Other

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record

Measure Steward: PCPI Foundation

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-4; M-8; L-1; I-0**; 1b. Performance Gap: **H-3, M-7, L-3, I-0**

Rationale:

- This newly-submitted measure is eligible for Approval for Trial Use.

- The developer presented guidelines from two societies (American Association for the Study of Liver Diseases [AASLD] and Infectious Disease Society of American [IDSA]) that recommend "persons should be screened for risk factors for HCV infection, and one-time testing should be performed for all persons with behaviors, exposures, and conditions associated with an increased risk of HCV infection" and high risk individuals and persons born between 1945 and 1965 without prior ascertainment of risk."
- The Quality, Quantity, and Consistency for all guidelines and USPSTF guidelines were provided with the submission.
- Committee members questioned the developer about the availability of recent data on screening performance gaps.
- Since this is a new measure without performance data from use of the measure, the developer cited data from Indian Health Services that includes 1.9 million members and 566 Federally recognized tribes. Through a wide network of facilities, screening in this cohort was assessed, including one-time cohort screening for those at risk. From 2012 to 2015 the baseline rate increased from 7.9 percent to 32.5 percent. The study also showed gender and regional variation in screening; more women received screening than men and regions varied from 31.2% to 41.2%.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2. Specifications: **H-4; M-8; L-1; I-0**

Rationale:

- The submitted eMeasure specifications follow the industry accepted format for eMeasure (HL7 Health Quality Measures Format (HQMF)).
- All components in the measure logic of the submitted eMeasure are represented using the HQMF and QDM.
- The submitted eMeasure specifications use existing value sets, which are used within the measure, published within the Value Set Authority Center (VSAC), and are available for public use.
- The measure submission included test results from a simulated data set demonstrating the measure logic can be interpreted precisely and unambiguously. The testing included data from three separate EHRs, totally approximately 27,000 patients and demonstrated that the logic works correctly and that the appropriate metric is calculated.
- The submission contained a feasibility assessment that addresses data element feasibility and follow-up with the developer indicated that the measure logic is feasible based on assessment by EHR vendors. The feasibility scorecard was included with an evaluation of each data element across each EHR system, showing that data was available, standardized, and did not interrupt workflow.
- This eMeasure has not been tested. With this submission the developer is applying for the Trial Use program. The Trial Use program is available to encourage use of eMeasures so that sufficient data can be collected to adequately test measures, as required by NQF endorsement.
- BONNIE testing was performed to assess the measure algorithm. Results indicated an accurate calculation from the algorithm.
- The developer indicated the testing that will be performed when sufficient data are collected from use of the measure.

- The developer plans to assess face validity when sufficient data are available to evaluate.
-

3. Feasibility: H-1; M-10; L-2; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- One Committee member questioned whether people who have a history of one-time test will be captured in the measure.
 - Committee members extensively discussed the high cost of HCV treatment strategies (e.g., medication), which Medicaid and facilities serving low-income, vulnerable populations like public health centers, cannot afford. Furthermore, HCV patients who continue to engage in high-risk behavior, increase the likelihood of re-infection, so screening and subsequent treatment are usually not one-time only.
 - The developer noted that even under the most restrictive Medicaid reimbursement criteria, HCV infected people would qualify for treatment.
 - The developer mentioned that HHS is examining how to reduce treatment expenses and shared results from CDC's societal cost effective modeling that indicate that HCV treatment cost are decreasing; in 2014, drugs cost per curative cost range from \$86,000 to \$94,000. Within two years, the price has fallen to \$46,000.
 - One Committee member raised the issue of broad implementation across different types of entities like health plans, HMOs, public health clinics and hospitals.
 - The developer mentioned that CDC is tracking testing using millions of records from two large commercial laboratories and noted a 60% increase in testing since the screening recommendations were put forth in 2012.
 - The Committee noted that increases in testing for HCV were noted across Medicaid populations, however, access to treatment, because of budgetary constraints for Medicaid programs remains a disincentive to test.
 - Finally, it was noted that the CDC, state health department, and Federally-Qualified Health Centers (FQHCs) are working together to improve access to HCV testing, follow-up and treatment.
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4. Usability and Use: H-1; M-8; L-3; I-1

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The developer listed the planned uses as "Payment Program" and "Quality Improvement with Benchmarking (external benchmarking to multiple organizations)," but did not provide specifics.
- The measure is a part of AHIP's Core Quality Measure Collaborative. The Collaborative intends to promote alignment and harmonization of measures across payers in the public and private sectors through core measure sets. CMS intends to include the core sets in proposed rules, where appropriate. Private payers will use a phased in approach to implementation of the core measure sets and may use them for negotiations between physicians and private payers.
- MAP 2014-2015: MAP encouraged continued development of this population health screening eMeasure aligned with CDC recommendations.

5. Related and Competing Measures

- 0393: Hepatitis C: Confirmation of Hepatitis C Viremia

Standing Committee Recommendation for eMeasure Approval for Trial Use: Y-11; N-2

6. Public and Member Comment

Comments received:

- One commenter supported the recommendation of the Committee for continued endorsement of the measure.

Developer response:

- Measure 3059 is designed to promote the identification of hepatitis C to ensure early intervention and proper management of the virus through one-time screening for the birth cohort and other at risk populations. The measure, as drafted, is designed to be consistent with the recent recommendations from the CDC and USPSTF which outline various target populations for screening. As noted in the CDC recommendations, the recommendation for screening persons born during 1945-1965 does not replace previous guidelines for HCV testing that are based on known risk factors and clinical indications, but rather it defines an additional target population for one-time testing with the goal of achieving greater success in disease identification and engagement into treatment than risk-based strategies alone. HCV testing is the first step toward improving health outcomes for persons infected with HCV given that most persons with HCV do not know they are infected, do not receive needed care (e.g., education, counseling, and medical monitoring), and are not evaluated for treatment. Additionally, the measure has undergone initial feasibility testing at two different sites which supported the current measure construction and failed to identify any significant challenges in identifying or collecting the various data elements included in the measure. Additional testing will be conducted to meet additional NQF requirements and to advance the measure from approval for trial use to full endorsement.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for trial use

3060 Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users

[Submission](#) | [Specifications](#)

Description: Percentage of patients, regardless of age, who are active injection drug users who received screening for HCV infection within the 12 month reporting period

Numerator Statement: Patients who received screening for HCV infection within the 12 month reporting period

Denominator Statement: All patients, regardless of age, who are seen twice for any visit or who had at least one preventive care visit within the 12 month reporting period who are active injection drug users

Exclusions: Denominator Exclusions:

Patients with a diagnosis of chronic hepatitis C

Denominator Exceptions:

Documentation of medical reason(s) for not receiving annual screening for HCV infection (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons)

Documentation of patient reason(s) for not receiving annual screening for HCV infection (eg, patient declined, other patient reasons)

Adjustment/Stratification: No risk adjustment or risk stratification.

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Setting of Care: Ambulatory Care : Clinician Office/Clinic, Home Health, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Other

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

Measure Steward: PCPI Foundation

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-8; L-2; I-1**; 1b. Performance Gap: **H-2; M-8; L-0; I-2**

Rationale:

- This newly-submitted eMeasure is eligible for Approval for Trial Use.
- The developer presented guidelines from the American Association for the Study of Liver Diseases (AASLD) and Infectious Disease Society of American (IDSA) that recommend annual HCV testing for persons who inject drugs and for HIV-seropositive men who have unprotected sex with men. Periodic testing should be offered to other persons with ongoing risk factors for exposure to HCV.
- The Quality, Quantity, and Consistency for all guidelines, including a 2013 USPSTF guideline were provided with the submission.
- Committee members, however, debated whether annual screening as specified in the measure is aligned with the guidelines. The developer confirmed that it is aligned with the AASLD guideline for one-year screening and generally aligned with the USPSTF, which recommends "periodic screening" for at-risk populations, including IVD users.
- Since this is a new measure without performance data from use of the measure, the developer cited data from the literature that show that 72% of persons with a history of injection-drug use and are infected with HCV, remain unaware of their infection status.
- The developer also noted that, according to the CDC, American Indians and Alaska natives have the highest incidence of acute HCV cases. While African Americans make up 12% of the U.S.

population, they account for more than 22% of chronic HCV cases. African Americans diagnosed with HCV infection often have less desirable outcomes compared to white patients. In addition, chronic liver disease, often related to HCV infection, is a leading cause of death among African Americans aged 45-64. One study found that minorities had lower treatment rates than whites, despite fewer medical and psychiatric comorbidities, higher incomes and educational levels. Asians had the lowest treatment rates and Hispanics have lower levels of treatment compared to whites, despite a higher incidence of cirrhosis.

- One Committee member suggested the developer assess both active injection drug use and non-IVD within the Indian Health Services catchment because performance gaps in screening for HCV generally may exist.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2b. Specifications: **H-0; M-10; L-3; I-0**

Rationale:

- The specifications for this eMeasure follow the industry accepted format for eMeasure (HL7 Health Quality Measures Format (HQMF)).
- All components in the measure logic of the submitted eMeasure are represented using the HQMF and QDM.
- The specifications use existing value sets when possible and new value sets that have been vetted through the Value Set Authority Center (VSAC), with the exception of a couple of value sets which were not in structured form within 1 of the EHRs.
- The submission included test results from a simulated data set demonstrating the measure logic can be interpreted precisely and unambiguously; in addition, the developer also tested in two sites and was able to implement with minimal difficulty.
- The feasibility analysis submitted by the measure developer meets the requirements to be considered for eMeasure Trial Approval. However, the variability in the structured/non-structured elements may signal an issue with implementation. While the developer outlined the pathway for the elements to be structured in the future, the current implementation indicates that the information may be collected differently, which may pose some difficulties in getting the information needed to obtain an appropriate metric for the measure.
- The specifications are not completely consistent with the evidence. The developer confirmed that the measure is aligned with the AASLD guideline for one-year screening and generally aligned with the USPSTF, which recommends “periodic screening” for at risk populations, including IVD users.
- This eMeasure has not been tested. With this submission, the developer is applying for the Trial Use program and not NQF endorsement. The Trial Use program is available to encourage use of eMeasures so that sufficient data can be collected to adequately test measures, as required by NQF endorsement.
- BONNIE testing of a synthetic data set of 38 patients was provided. The developer did not summarize the findings from the BONNIE testing.
- The developer described the plan to test the reliability of the measure.
- Committee members questioned the sensitivity and specificity of identifying intravenous drug use (IVDU) from medical records. When the measure returns with testing data, the Committee suggested the developer not only include IVDU data from the social history, but also information

from recent emergency department visits, hospitalization, and other healthcare resource use associated with overdose, treatment, referrals etc.

- One Committee member suggested that the developer consider how to quantify and differentiate “history of IVDU” from “active IVDU” because active users often go in and out of detox.

3. Feasibility: H-0; M-11; L-2; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- This is an untested eMeasure for consideration in the Trial Use program. It is not being considered for NQF endorsement.
- The developer provided a feasibility assessment.

4. Usability and Use: H-0; M-11; L-2; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The developer lists the planned uses as "Payment Program" and "Quality Improvement with Benchmarking (external benchmarking to multiple organizations)" but did not provide specifics.
- In 2014-2015, the MAP encouraged further development of this measure (3060) and Measures 3059 and 3061 for potential, future inclusion in the Meaningful Use and PQRS programs.
- MAP also recommended combining or pairing the screening follow-up (Measure 3061) with the one-time screening measure (Measure 3059).

5. Related and Competing Measures

- 0393: Hepatitis C: Confirmation of Hepatitis C Viremia
 - The developer noted this measure and Measure 0393 are not harmonized. According to the developer, "The quality action performed in measure 0393 is confirming the hepatitis C antibody is present following initial testing and does not include the initial testing before diagnosis as a part of the quality action performed in the measure."
- 0398: Hepatitis C Virus (HCV) Ribonucleic Acid (RNA) Testing Between 4-12 Weeks after Initiation of Treatment
- 0395: Paired Measure: Hepatitis C Ribonucleic Acid (RNA) Testing Before Initiating Treatment (paired with 0396)
- 0396: Paired Measure: Hepatitis C Virus (HCV) Genotype Testing Prior to Treatment (paired with 0395)

Standing Committee Recommendation for eMeasure Approval for Trial Use: Y-11; N-2

6. Public and Member Comment

Comments received:

- One commenter supported the recommendation of the Committee for continued endorsement of the measure.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for trial use

3061 Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection

[Submission](#) | [Specifications](#)

Description: Percentage of patients aged 18 years and older with either (1) a positive HCV antibody test result and a positive HCV RNA test result 1or (2) a positive HCV antibody test result and an absent HCV RNA test result who are prescribed treatment or are referred to evaluation or treatment services

Numerator Statement: Patients who are prescribed treatment or are referred to evaluation or treatment services

Denominator Statement: All patients aged 18 years and older who are seen twice for any visit or who had at least one preventive visit with either (1) a positive HCV antibody test result and a positive HCV RNA test result or (2) a positive HCV antibody test result and an absent HCV RNA test result

Exclusions: Denominator Exclusions:

Patients with a negative HCV RNA result, patients with a diagnosis of chronic hepatitis C

Denominator Exceptions:

Documentation of medical reason(s) for not prescribing treatment or being referred to evaluation or treatment services (eg, participation in a clinical trial, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons)

Documentation of patient reason(s) for not prescribing treatment or being referred to evaluation or treatment services (eg, patient declined, other patient reasons)

Adjustment/Stratification: No risk adjustment or risk stratification.

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician: Group/Practice, Clinician: Individual

Setting of Care: Ambulatory Care: Clinician Office/Clinic, Home Health, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility, Other

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record

Measure Steward: PCPI Foundation

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-7; M-4; L-2; I-0**; 1b. Performance Gap: **H-7; M-5; L-1; I-0**

Rationale:

- This newly-submitted eMeasure is eligible for Approval for Trial Use.
- The Quality, Quantity and Consistency for all guidelines, including a 2013 USPSTF guideline, is provided with the submission.
- CDC recommends: "Persons who test positive for both HCV antibody and HCV RNA should be informed that they have HCV infection and need further medical evaluation for liver disease, ongoing medical monitoring, and possible treatment."
- According to the American Association for the Study of Liver Diseases (AASLD) and Infectious Disease Society of American (IDSA), only an estimated 13% to 18% of HCV-infected persons in the United States received treatment by 2013
- Since this is a new measure without performance data from use of the measure, the developer provided data from the literature. One study found that only 63 to 77% of people who have tested positive for HCV antibodies—32 to 38% of all HCV-infected people in the United States—received follow-up hepatitis care, only 5-6% of all individuals. Likewise, a survey of 494 primary care clinicians practicing in low-income medically underserved communities across the United States found that 54% of clinicians refer 75% or fewer patients; less than 18% of clinicians provide antiviral treatment. Key factors influencing a physician's decision to treat patients with HCV include patient comorbidities, access to care, and treatment tolerance for patients who are infected with HCV.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2. Scientific Acceptability: **H-2; M-9; L-2; I-0**

Rationale:

- The eMeasure specifications follow the industry accepted format for eMeasure (HL7 Health Quality Measures Format (HQMF)).
- All components in the measure logic of the submitted eMeasure are represented using the HQMF and QDM and are accepted within the model.
- The submitted eMeasure specifications use existing value sets when possible and use new value sets that have been vetted through the Value Set Authority Center (VSAC), with the exception of a couple of value sets which were not in structured form within 1 of the EHRs used, but are relatively common data elements.
- The measure submission included test results from a simulated data set demonstrating the measure logic can be interpreted precisely and unambiguously; in addition, the developer also tested in two sites and was able to implement with minimal difficulty.
- The feasibility analysis submitted by the measure developer meets the requirements for eMeasure Trial Approval Use consideration. However, the variability in the structured/non-structured elements may signal a concern with implementation. While the developer outlined the pathway for structuring data in the future, the current submission indicated that information may be collected differently. This may make it difficult to obtain appropriate data for the measure.

- This eMeasure has not been tested. With this submission the developer is applying for the Trial Use program and not NQF endorsement. The Trial Use program encourages use of eMeasures so that sufficient data can be collected to adequately test measures, as required by NQF endorsement.
- The developer provided BONNIE testing of a synthetic data set of 52 patients, but did not summarize the findings from the BONNIE testing.
- The developer described how it plans to test the reliability of the measure.
- The Committee noted gaps between referral and treatment, and the challenges of assessing follow-up and meaningful adequacy. When the measure is submitted for endorsement consideration, with testing data, the Committee would like to review a measurement construct, with testing results and specifications, for both referral and treatment; The Committee strongly believes that assessing referral for HCV treatment alone would fall short of meaningful, comprehensive improvement.
- The developer said it conducting a cohort study in four sites and working with referral data within health system databases to assess linkages to HCV care and treatment.
- One Committee member suggested the developer segment referral in two parts: First, assess whether the PCP referred the patient to a specialist; and second, assess whether the patient visited the specialist.

3. Feasibility: H-2; M-10; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The measure specifications are consistent with the evidence.
- A feasibility assessment for this eMeasure was provided.

4. Usability and Use: H-1; M-10; L-2; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The developer indicated that the planned use of the eMeasure is Quality Improvement with Benchmarking (external benchmarking to multiple organizations), however, the developer did not provide details.

5. Related and Competing Measures

- 0398: Hepatitis C Virus (HCV) Ribonucleic Acid (RNA) Testing Between 4-12 Weeks after Initiation of Treatment
- 0393: Hepatitis C: Confirmation of Hepatitis C Viremia
- 0395: Paired Measure: Hepatitis C Ribonucleic Acid (RNA) Testing Before Initiating Treatment (paired with 0396)
- 0396: Paired Measure: Hepatitis C Virus (HCV) Genotype Testing Prior to Treatment (paired with 0395)

Standing Committee Recommendation for eMeasure Approval for Trial Use: Y-11; N-2

6. Public and Member Comment

No comments were received on this measure during public and member comment.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-15; N-0

- **Decision:** Approved for trial use

Measures Not Endorsed

3067 Human Immunodeficiency Virus (HIV) Infection Screening

[Submission](#) | [Specifications](#)

Description: Percentage of patients 15-65 years of age who were tested at least once for HIV.

Numerator Statement: Patients with either documentation of an HIV test after their 15th birthday or evidence of HIV infection.

Denominator Statement: Patients 15 to 65 years of age who had a visit in the measurement period*.

*The measurement period refers to a defined, 12 month interval that begins and ends prior to the measure calculation date.

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification.

The numerator should be reported according to the following 3 strata:

- Stratum 1: Patients with HIV Testing Performed;
- Stratum 2: Patients with prior diagnosis of HIV infection;
- Stratum 3: Patients with either HIV Testing Performed or prior diagnosis of HIV infection

In essence, Stratum 3 looks at the numerator population as a whole, while strata 1 and 2 look at two distinct, key sub-populations within the numerator population (i.e., those for whom testing evidence is direct and in the form of a lab order or result, and those for whom testing evidence is indirect or implicit, based on the presence of an HIV diagnosis code)

The proposed stratification allows individuals seeking to use the measure results (e.g., for performance assessment and comparison or quality improvement activities) to differentiate between physicians whose performance may be driven by their having a large number of persons living with HIV (PLWH) among their patients and physicians whose performance may be driven by their HIV screening practices vis-à-vis persons who are not known, at the time of their testing, to be living with HIV. It is not unreasonable to argue that comparing performance between the two groups of providers favors the former (those treating large numbers of PLWH) and disadvantages the latter (more typically primary care providers with limited experience—or occasion—to actively oversee the care of large numbers of PLWH): the combination of still evolving EHRs and an “ever” look back period necessarily favors calculations based on more typically recurrent or recently used data elements (i.e., diagnoses, relative to results for a specific lab).

Detailed data elements and code sets available in Zipped Folder titled “HIVScreening_v4_Tue Feb 24 22.20.27 CST”

Level of Analysis: Facility, Clinician : Group/Practice

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Process

Data Source: Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

Measure Steward: Centers for Disease Control and Prevention

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-10; M-5; L-0; I-0**; 1b. Performance Gap: **H-12; M-3; L-0; I-0**

Rationale:

- This new, HIV infection screening measure is based on a 2013 US Preventive Services Task Force (USPSTF) guideline that recommends clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. The guideline also recommends that younger adolescents and older adults who are at increased risk should also be screened. Grade A: High Certainty of Net Benefit. (Moyer, 2013).
- USPSTF found no direct evidence on the effects of screening versus no screening on clinical outcomes. Since the 2013 USPSTF recommendation, however, the developer reported that two randomized controlled trials have demonstrated that immediate initiation of anti-retroviral therapy meaningfully affects morbidity, mortality, and forward transmission.
- The Committee asked whether the measure captures patients who are screened, diagnosed, and referred to timely, appropriate care. The developer cited surveillance data that show approximately 70% of HIV infected patients receive care within three months of diagnosis. However, the developer also noted the difficulty of assessing these linkages, especially referral documentation in electronic health records (EHRs). The developer also mentioned unsuccessful uptake of measures that assess retention in care.
- Committee members questioned the upper age limit of 65 years. The developer acknowledged interest within the CDC in reexamining the upper age bound, but doubted widespread uptake in the absence of aligned USPSTF guidelines.
- The Committee asked why the lower age limit is 15 years, while the CDC recommends screening to begin at age 13. The developer noted significant resistance from influential stakeholder groups when attempts were made to align the measure with CDC's lower age limit.
- The Committee also discussed the challenges of adequately assessing screening for adolescents, specially related to confidentially and unintended consequences of disclosing screening to their parents through insurance claims.
- One Committee member noted that "testing" and "screening" were used interchangeably. The CDC uses screening to refer to a generalized assessment of HIV infection, not dependent on risk. Whereas testing is used to refer to risk-based or diagnostic testing.
- Several Committee members questioned how "evidence of HIV infection" in the numerator can be substantiated without testing. The developer noted that this was included to capture patients with HIV who were tested or screened at some point. The developer is willing to remove this data element from the numerator and denominator to minimize confusion.
- The developer does not have national gap information for this new measure, however testing at four community health centers (CHC) found a range of 20.6-31.1%. Results for a fifth CHC with a significant high-risk pool were 65.3%.
- 2011 data from the Behavioral Risk Factor Surveillance System (BRFSS) found that for adults 18-64 years,
 - 66.2% of Blacks/African Americans, 44.8% of Hispanics, 38.1% of Whites and 38.8% of other races/ethnicities reported ever being tested for HIV.

2. Scientific Acceptability of Measure Properties: The measure failed to meet the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-5; L-5; I-5**; 2b. Validity: **H-X; M-X; L-X; I-X**

Rationale:

- This is a Health Quality Measures Format-compliant (HQMF) eMeasure.
- All components in the measure logic of the submitted eMeasure are represented using the HQMF and Quality Data Model (QDM).
- The submitted eMeasure specifications use existing value sets when possible and use new value sets that have been vetted through the Value Set Authority Center (VSAC).
- The measure submission includes test results from five Chicago-area community health centers (CHC) that belong to a Health Center Controlled Network and using GE Centricity Practice Solutions (3 versions among the five sites) and that demonstrate the measure logic can be interpreted precisely and unambiguously.
- The submission contained a feasibility assessment of the data elements. For one organization (five sites), data availability, data accuracy, and workflow scored three for each criterion (best possible score). For the second organization, the developer stated the feasibility assessment was conducted early in the development process, so two elements were not included; no information on individual criterion was provided for this early phase assessment. Follow-up with the developer indicated the measure logic is feasible based on an assessment by EHR vendors.
- The developer assessed empirical reliability at the data element level and validity of the measure score.
- Data element testing used a random sample of 300 charts; 100 patients who met the measure and 200 who did not were pulled for chart review. Data element testing results were 96% sensitivity, 100% specificity, and kappa=0.97. The developer concluded results represent a highly valid and reliable representation of the numerator elements between the manual vs. automated extractions.
- Score-level testing involved examining performance at the five different CHCs, each of which involved multiple care sites and three versions of the GE Centricity platform, and also comparing these score results to other practices with established EHRs (Kaiser Permanente Mid-Atlantic States and the Department of Veterans Affairs).
- For score-level testing, the developer concluded the share of visits ever screened in its sample “compares favorably” (20.6-65.3%) to the data from Kaiser (35% screened) and VA (22.9% screened for VA facilities in Chicago area).
- The Committee raised concern about reliability testing of the data elements in the EHR; specifically, it questioned how patients who opt out were handled; limited geographic focus on Chicago; and verification of previous screening or test without self-reporting.
- The developer confirmed that opt outs are not factored into the measure because screening should be part of standard practice. With regard to geographic variation, the developer confirmed future testing in other cities and in different health systems. Finally, the developer acknowledged potential over-testing with this measure, but concluded that the value of testing outweighed the potential risk of over-testing.
- Some concerns were raised about the inclusion of HIV status in the numerator and the cumulative effect on the measure’s ability to discern meaningful differences in HIV infection screening for accountability purposes.
- While the Committee was generally supportive of the measure, several concerns were raised about the numerator and denominator. Ultimately, the measure failed the Reliability criterion.

3. Feasibility: H-X; M-X; L-X; I-X

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

4. Usability and Use: H-X; M-X; L-X; I-X

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

5. Related and Competing Measures

- This measure directly competes with [NQF # and Title] [Description]. [Summarize the related/competing measure issue here, and the disposition of it]

OR

- No related or competing measures noted.
-

Standing Committee Recommendation for Endorsement: Y-X; N-X

6. Public and Member Comment

No comments were received on this measure during public and member comment.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-0; N-15

- **Decision: Measure not endorsed**
-

3071 Follow-up Referral after Positive Developmental Screen

[Submission](#) | [Specifications](#)

Description: Percentage of patients aged 6 to 36 months who were referred for follow-up care within 7 calendar days of receiving a positive developmental screening result.

Numerator Statement: Patients who received a referral for follow-up care (1) by the screening clinician within 7 calendar days of receiving a positive developmental screening result (2)

Denominator Statement: All patients aged 6 months to 36 months who received a positive developmental screening result through the use of a validated screening tool or an indication from the family that there is a developmental concern.

Exclusions: Patients who did not receive a developmental screen using a validated developmental screening tool or who have already received or are receiving therapy, intervention, or education that would also be applicable for developmental delay follow-up care.

Adjustment/Stratification: No risk adjustment or risk stratification.

This measure does not require stratification or risk adjustment.

Level of Analysis: Clinician: Group/Practice, Clinician: Individual, Integrated Delivery System

Setting of Care: Ambulatory Care: Clinician Office/Clinic

Type of Measure: Process

Data Source: Electronic Clinical Data: Electronic Health Record

Measure Steward: Northwestern University

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-2; L-2; I-11**; Evidence Exception: **Y-10; N-5**; 1b. Performance Gap: **H-6; M-7; L-2; I-0**

Rationale:

- The developer provides information in support of a 2006 recommendation of the American Academy of Pediatrics (AAP), reaffirmed in 2014. The guideline is based on consensus/expert opinion and recommends that if developmental screening results are concerning, the child should be scheduled for developmental and medical evaluations as quickly as possible, and professionals should coordinate activities and share findings.
- However, the developer cited other data, including a 2016 USPSTF systematic review, which concluded insufficient or inconsistent evidence exists to recommend for or against routine use of brief, formal screening instruments in primary care to detect speech and language delay in children up to five years of age.
- The developer also noted that 34-37% of high-risk infants and 61% of young children who fail a developmental screen are not referred for further evaluation.
- The Committee noted evidence that early intervention for children with developmental delays improves the outcome, but debated whether referrals per se result in improved patient outcomes.
- To strengthen the measure, 1 Committee member suggested the developer include an assessment of whether the patient received the necessary care or treatment after referral. The developer stated it is testing another measure that tracks referral, follow-up, and whether the family actually followed up and was/is actively engaged in further evaluation or treatment.
- Committee members also questioned the appropriateness of referral versus scheduling a follow-up visit or monitoring development over time. The developer explained the time-sensitive nature of many developmental delays.
- The Committee questioned whether the 7-day referral period was substantiated in the literature: Ideally, a child with a positive developmental screen should receive a referral on the same day. The developer responded that its expert panel recognized that some practices will not be able to reach this benchmark, and therefore recommended referrals within seven days.
- The developer noted significant disparities in the use of validated developmental screen tools. Nationwide, providers used validated tools to evaluate children approximately 80% of the time; safety net providers used validated tools about 38% of the time.
- Following lengthy discussion, the Committee agreed that referral is an important intermediary step in the sequence of developmental screen, follow-up, treatment, and re-evaluation process and voted for Evidence with Exception.

- This is a new measure, so extensive performance gap information from implementation is unavailable; the developer provided performance data from four Chicago primary care network test sites (range 31-100%, N=15 charts) and the private pediatrics practice in North Carolina (23%, N=12 charts).

2. Scientific Acceptability of Measure Properties: The measure failed to meet the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-6; L-7; I-2**; 2b. Validity: **M-2; L-5; I-7**

Rationale:

- Reliability testing was conducted using a chart abstraction tool. Inter-rater reliability between abstractors was assessed for each element of the measure; measure performance also was calculated and compared between abstractors.
- The developer tested the measure in two cohorts: primary care practice networks for four hospitals in the Chicago Pediatric Quality and Safety Consortium; and Ashe Pediatrics, a private pediatrics practice in North Carolina. (N=117 charts, data period of 1/1/13-12/31/14)
- Overall agreement and kappa statistic for the use of a validated screening tool was 93.6%, with a kappa of 0.87.
- Agreement on the denominator criteria, patients with a positive developmental screening result, was 99.29%, with a kappa of 0.964.
- Agreement and kappa for the numerator criteria, patients who received a referral for follow-up care by the screening clinician within seven calendar days of receiving a positive developmental screening result, was 73.0%, with a kappa of 0.38.
- The developer attributes the lower kappa for the numerator criteria to the drop-off in charts meeting the denominator (N=16). The developer further reported that kappa values in the range of 0.4 to 0.75 are considered fair to good, again positing that 0.38 falls just below this range because of sample size.
- The developer conducted empirical validity testing at the data element. This methodology assesses reliability, not validity.
- The developer conducted face validity through an open comment period by stakeholders; the developer reports more than 100 individuals commented.
- One Committee inquired about the geographic diversity of the stakeholder group, but the developer was unable to confirm the composition of the group.
- The developer reported that 65% of respondents agreed the measure is "extremely valid," (8-9 score).
- The developer concluded the face validity assessment indicates performance on this measure would be useful for quality improvement.
- Many of the issues that the Committee discussed related to Evidence (e.g., proximity of the process [referral for follow-up] to improved patient outcomes), were raised during the validity testing discussion. Additionally, Committee members raised significant concern with the definition of referral and small sample size for testing.
- Ultimately, the measure failed the Validity criterion.

3. Feasibility: H-X; M-X; L-X; I-X

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

4. Usability and Use: H-X; M-X; L-X; I-X

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

5. Related and Competing Measures

- No related or competing measures noted.
-

Standing Committee Recommendation for Endorsement: Y-X; N-X

6. Public and Member Comment

No comments were received on this measure during public and member comment.

3087 Completion of a Malnutrition Screening within 24 hours of Admission

[Submission](#) | [Specifications](#)

Description: Completion of a malnutrition screening to determine if a patient is at-risk for malnutrition, within 24 hours of admission to the hospital

Numerator Statement: Patients in the denominator who have a completed malnutrition screening documented in the medical record within 24 hours of admission to the hospital. For the purposes of this measure, it is recommended that a malnutrition screening be performed using a validated screening tool which may include but is not limited to one of the following validated tools:

Malnutrition Screening Tool (MST) (Wu, 2012), Nutrition Risk Classification (NRC) (Kovacevich, 1997), Nutritional Risk Index (NRI) (Honda, 2016), Nutritional Risk Screening 2002 (NRS-2002) (Bauer, 2005), Short Nutrition Assessment Questionnaire (SNAQ) (Pilgrim, 2016).

Bauer JM, Vogl T, Wicklein S, Trögner J, Mühlberg W, Sieber CC. Comparison of the Mini Nutritional Assessment, Subjective Global Assessment, and Nutritional Risk Screening (NRS 2002) for nutritional screening and assessment in geriatric hospital patients. *Z Gerontol Geriatr.* 2005;38(5):322-7.

Kovacevich DS, Boney AR, Braunschweig CL, Perez A, Stevens M. Nutrition risk classification: a reproducible and valid tool for nurses. *Nutr Clin Pract.* 1997;12(1):20-5.

Honda Y, Nagai T, Iwakami N, et al. Usefulness of Geriatric Nutritional Risk Index for Assessing Nutritional Status and Its Prognostic Impact in Patients Aged ≥65 Years With Acute Heart Failure. *Am J Cardiol.* 2016;

Pilgrim AL, Baylis D, Jameson KA, et al. Measuring Appetite with the Simplified Nutritional Appetite Questionnaire Identifies Hospitalised Older People at Risk of Worse Health Outcomes. *J Nutr Health Aging.* 2016;20(1):3-7.

Wu ML, Courtney MD, Shortridge-baggett LM, Finlayson K, Isenring EA. Validity of the malnutrition screening tool for older adults at high risk of hospital readmission. J Gerontol Nurs. 2012;38(6):38-45.

Denominator Statement: All patients age 18 years and older at time of admission who are admitted to an inpatient hospital

Exclusions: No denominator exclusions for this measure.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

Data Source: Electronic Clinical Data : Electronic Health Record

Measure Steward: Avalere Health/Academy of Nutrition & Dietetics

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure does not meet the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-8; L-3; I-3**; 1b. Performance Gap: **H-4; M-9; L-2; I-1**

Rationale:

- For this new eMeasure, the developer presented 2011 guidelines from the American Society for Parenteral and Enteral Nutrition (ASPEN) that demonstrate that assessing nutrition risk, identified by nutrition screening is associated with longer length of hospital stay, complications, and mortality. The guidelines are based on nine observational studies; 1 non-randomized cohort with contemporaneous controls relating nutritional assessment to adverse patient outcomes.
- The developer noted that the guideline cited in support of this measure recommends screening for nutrition risk for all hospitalized patients; the guideline was rated Grade C.
- Committee members raised concern about the burden of screening each hospitalization (patients 18 and older) within 24 hours, regardless of patient risk or condition. The developer noted that screening for malnutrition is relatively straightforward. Furthermore, screening tools are sensitive enough to identify those at risk for malnutrition.
- Additionally, Committee members were concerned that the screening, assessment, diagnosis to treatment link was not substantiated by the evidence.
- The Committee questioned why the measure does not specify screening via a validated tool as supported by the evidence. The developer acknowledged the challenges with identifying a validated screening tool currently (i.e., selecting 1 tool that would meet every hospital's needs), but stated it anticipates implementation of the measure will help advance the need for such a tool.
- The Committee failed to reach consensus on the Evidence criterion.
- The developer cited a national survey of hospital-based professionals in the United States focused on nutrition screening and assessment practices and associated gaps in knowledge of nutrition care. Out of 1,777 unique respondents, only 36.7% reported completing nutrition screening at admission, and 50.8% reported doing so within 24 hours, and 69% reported documenting the findings in the medical record.
- The developer reposted an evidence synthesis prepared for the Agency for Healthcare Research and Quality (AHRQ) found that older African American patients as well as older Hispanic women

were at a higher risk of malnutrition compared to white patients. Some Committee members noted that performance gap information was derived from only two hospitals and therefore was concerned about generalizability.

- During the post-comment call, Committee members echoed concerns raised during the in-person meeting about the burden of screening each hospitalization (patients 18 and older) within 24 hours, regardless of patient risk or condition, as well as whether the screening to treatment link was substantiated by evidence. It was noted that the majority of comments received were in support of measures #3087, #3088, and #3089, but a Committee member felt that despite the large number of comments, no new information was provided and the Committee's previous concerns still stand. It was noted that many of the references included in comments were part of the original submission or addressed similar findings as before—i.e., that malnourished patients have increased lengths of stays, increased mortality, and other adverse health outcomes, but the references were not specific to the measures' foci (screening, completion of assessment, care plan). One Committee member noted that many articles looked at malnutrition and length of stay, but that did not seem the most relevant endpoint to be addressing for screening and food security—it should be about longer term health and impact on utilization cost.
- Two Committee members expressed support for the measure intent and one member referred the developer to recent work to inform their progress. Concerns existed around the denominator and its need for targeting beyond simply those 18 and older.
- The developer was provided the opportunity to address the Committee. The developer stated that exclusion criteria includes patients who have a length of stay of shorter than 24 hours. The developer stated that measure focuses on malnutrition screening, which is the first step in the process of addressing malnutrition.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-11; L-2; I-3**; 2b. Validity: **H-1; M-9; L-5; I-1**

Rationale:

- This eMeasure's specifications follow the industry accepted format for eMeasure (HL7 Health Quality Measures Format (HQMF)) and have been constructed with the appropriate elements from the QDM.
- The value sets used in the measure are published and available to the public through the VSAC, which complies with NQF criteria.
- The feasibility assessment is adequately scored, and the supporting documentation provided by the developer justifies the scores.
- The measure was tested in two sites using three EHR-systems; the developer indicated that the measure logic works correctly and is calculating an appropriate metric.
- Reliability testing was assessed using data element validity testing.
- Validity testing results found that of the 200 patient records that were included in the validation study, there was 100% agreement and a kappa statistic of 1.0 between the two sets of data extracted automatically and manually; this was for the data element that identifies the documentation of a completed malnutrition screening. For the data element that calculates which malnutrition screenings were completed in less than 24 hours, the percent agreement was slightly lower, (97.5%) and the kappa statistic was 0.87.

- With regard to sensitivity, the first data element (completed nutrition screening correctly), identification was 100%; it was slightly lower for the second data element (completed malnutrition screening within 24 hours [97.24%]). Percentage of patients who did not meet the criteria for the data element was 100% for completion of a screening and also 100% for those screenings completed within 24 hours. The EHR data set had 100% positive predictive value compared with the gold standard, which indicates the ability of the specifications to identify patients in the numerator. However, the ability of the specifications to accurately identify patients who *do not* meet numerator criteria was lower at 79.2%.
- One Committee member raised concern about the degree of variability in screening practice (i.e., who conducts the screening; how screening is defined) in the absence of a standardized screening tool and process.
- Another Committee member questioned why the measure as specified and submitted to NQF does not include exclusions, when exclusions were calculated during testing. (The three exclusions are patients who were discharged to hospice care; patients with a length of stay <24 hours; and patients who left against medical advice (AMA)). The developer explained that it conducted feasibility testing on excluded and non-excluded populations. For reliability and validity testing, specific measure exclusion analyses were assessed of the 200 patient records at both testing sites. The number of excluded patients was 3-5%; impact on the data element or performance results was negligible. The developer will consider adding excluded patients in the future, when more hospitals have implemented the measure.

3. Feasibility: H-2; M-12; L-2; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- This measure is specified for use in EHRs.
- A feasibility assessment rating the feasibility, in three different EHR systems at two sites, was included in the submission.
- The Committee raised no concerns about feasibility.

4. Usability and Use: H-0; M-11; L-5; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- This measure is currently used in the Academy of Nutrition & Dietetics and Avalere Health Malnutrition Quality Improvement Initiative. Both organizations are working with leading hospitals and health systems, as well as with other national stakeholders, in implementing a Malnutrition Quality Improvement Demonstration and Learning Collaborative focused on reducing clinical practice variability in malnutrition care through the implementation of a standardized toolkit, which includes the collection of data on malnutrition care provided in the inpatient setting; the Initiative focuses on internal quality improvement. Six medium to large hospitals and health systems across the country in six different states participate.
- This measure is intended for submission to the Centers for Medicare & Medicaid Services Measures Under Consideration pathway for the Inpatient Quality Reporting Program. The measure steward is also working with The Joint Commission for consideration as part of its

accreditation measures. The measure steward is seeking NQF endorsement in anticipation of this submission.

- One Committee raised concern about the degree of variability in screening practice (i.e., who conducts the screening; how screening is defined) in the absence of a standardized screening tool and process.
- Another Committee member asked whether this measure was aligned with CMS' screening for food and security that is part of the Accountable Health Communities Program. The developer responded that the CMS focus and current focus of the measure is on inpatient populations, however, the developer intends to expand the measure to capture at-risk elderly populations in home and community based settings.
- Concern was raised about the potential unintended consequences of endorsing this new, yet-to-be-implemented measure, without evidence demonstrating that screening leads to quality improvement. The developer agreed to update the measure submission with plans for future use by the next maintenance review.

5. Related and Competing Measures

- 3088: Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening
- 3089: Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment
- 3090: Appropriate Documentation of a Malnutrition Diagnosis
- The developer states that all four measures are harmonized.

Standing Committee Recommendation for Endorsement: Y-4; N-10

6. Public and Member Comment

Comments received:

- Forty comments (some multi-part) were received from 23 organizations/individuals and the developer for #3087. The comments were largely repetitive and listed the same references. Two additional references were included for comments on measure #3087. The first new article is from Kruizenga, which notes that Dutch hospitals are required to screen for undernutrition on the first day of admission. The study confirms other literature that reports that patients who are malnourished have longer LOS, but in this case specifically identified the patients through the use of a standardized screening tool. The second new article is from Allard and points to similar articles that malnutrition at admission "is prevalent and associated with prolonged LOS."
- In commenting on the measure, the developer notes it submitted a series of four measures that, in part, build on each other. Specifically, with respect to screening, the developer posits that #3087 triggers all subsequent care, noting the numerator for this measure becomes the denominator for #3088. The developer expresses concern that the lack of the initial universal screening (#3087) measure may lead to uneven implementation (i.e., ad hoc identification of the denominator) of the other measures.

Committee response:

- Though we appreciate the support the nutrition measures received during the member and public commenting period, we see no salient information in the new addition provided. We remain concerned about the lack of evidence linking screening every patient to improved

outcomes and also are concerned with the burden it would cause to screen every hospitalized patient, regardless of patient risk or condition, within 24 hours. We also are concerned about the lack of exclusions—including, for example, hospice patients or patients discharged against medical advice.

We understand and agree that malnourished patients have increased lengths of stays, increased mortality, and other adverse health outcomes, but the references the developer provided and those identified in the comment period are not specific to the measures' focus.

For the measure to be evaluated differently, evidence is needed that documents the impact on longer-term health because of screening, as well as the impact on utilization cost.

Developer response:

- Exclusion criteria includes patients who have a length of stay of shorter than 24 hours. The measure focuses on malnutrition screening, which is the first step in the process of addressing malnutrition.

3088 Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening

[Submission](#) | [Specifications](#)

Description: Patients age 65 years and older identified as at-risk for malnutrition based on a malnutrition screening who have a nutrition assessment documented in the medical record within 24 hours of the most recent malnutrition screening.

Numerator Statement: Patients in the denominator who have a nutrition assessment documented in the medical record within 24 hours of the most recent malnutrition screening.

Recommended nutrition assessment tools include: Subjective Global Assessment (Detsky, 1987), Patient Generated Subjective Global Assessment (Bauer, 2002), Nutrition-Focused Physical Exam (White, 2012)

Detsky AS, McLaughlin JR, Baker JP, et al. What is subjective global assessment of nutritional status?. JPEN J Parenter Enteral Nutr. 1987;11(1):8-13.

Bauer J, Capra S, Ferguson M. Use of the scored Patient-Generated Subjective Global Assessment (PG-SGA) as a nutrition assessment tool in patients with cancer. Eur J Clin Nutr. 2002;56(8):779-85.

White JV, Guenter P, Jensen G, et al. Consensus statement: Academy of Nutrition and Dietetics and American Society for Parenteral and Enteral Nutrition: characteristics recommended for the identification and documentation of adult malnutrition (undernutrition). JPEN J Parenter Enteral Nutr. 2012;36(3):275-83.

Denominator Statement: Patients age 65 years and older who were identified as at-risk for malnutrition upon completing a malnutrition screening.

Exclusions: Denominator exclusions include:

- Length of Stay <24 hours

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

Data Source: Electronic Clinical Data: Electronic Health Record

Measure Steward: Academy of Nutrition and Dietetics

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure does not meet on the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-6; L-8; I-0**; 1b. Performance Gap: **H-3; M-11; L-1; I-0**

Rationale:

- For this new eMeasure, the developer presented 2011 guidelines from the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) that recommends nutrition support intervention for patients identified by screening and assessment as at risk for malnutrition or malnourished. The developer noted in the submission a Grade C rating.
- The guidelines are based on three small, randomized trials, one nonrandomized cohort with historical controls, and 1 nonrandomized cohort with contemporaneous control.
- Committee members noted a discrepancy with the evidence rating. The developer inadvertently cited another part of the guideline and intended to cite the part that suggests nutrition assessment for all patients who were identified to be a nutrition risk by nutrition screening; the rating for this part of the guideline is Grade E. The developer will update the measure submission before NQF Member and public comment.
- Some Committee members debated whether the number of studies in the observation and randomized trials mentioned above were sufficient, and able to discern the risk of bias.
- Ultimately, the Committee failed to reach consensus on the Evidence criterion.
- The developer data from the literature to demonstrate a performance gap for this screening measure. A national survey of hospital-based professionals in the United States focused on nutrition screening and assessment practices and associated gaps in knowledge of nutrition care. Out of 1,777 unique respondents, only 23.1% reported using a validated assessment tool to help identify clinical characteristics for a malnutrition diagnosis.
- On the post-comment call, a Committee member noted that the guideline cited is based on three trials, and even among those there were inconsistencies in the evidence and they were rather limited; nothing new was added by the literature cited by the new comments. It was noted the many comments received were largely repetitive and supplied many of the same references, which do not directly link the completion to outcome. The developer noted that it provided several studies looking at the impact of quality improvement programs focused on nutrition and malnutrition. A Committee member responded that it's not just the publication of articles, but also the quality of the articles—what the study evaluated and whether it is even a good study and applies to a performance measure. NQF staff also noted that the evaluation criteria specifically call for an assessment of quality, quantity, and consistency of evidence.
- Ultimately, the measure did not pass on Evidence but the outcome was such that the additional votes might have meant passing the criterion. Accordingly, the Committee members also voted on Overall Suitability for Endorsement. Ultimately, #3088 is not recommended; it did not pass on Evidence, and it failed the vote on Overall Suitability, which was Y-5; N-9.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **M-14; L-3; I-0**; 2b. Validity: **M-12; L-3; I-2**

Rationale:

- This eMeasure’s specifications follow the industry accepted format for eMeasure (HL7 Health Quality Measures Format (HQMF)) and have been constructed with the appropriate elements from the Quality Data Model (QDM).
- The value sets used in the measure are published and available to the public through the Value Set Authority Center (VSAC), which complies with NQF criteria; however, Avalere has yet to fill out the purpose statements for each of their value sets.
- The feasibility assessment is adequately scored, and the supporting documentation justifies the scores.
- The measure was tested in two sites using three electronic health record (EHR)-systems, indicating that the measure logic works correctly and is calculating an appropriate metric for this measure.
- Reliability testing was assessed using data element validity testing.
- Validity testing results found that of the 200 patient records that were included in the validation study, there was 92% and 93% agreement, respectively, between abstractor and machine at facilities 1 and 2; and Kappa statistics were .42 and 0.75 between the two sets of data extracted automatically and manually. The data element nutrition assessment had a high percentage agreement and Kappa, 0.96 and .95 for facility 1 and, as well as strong sensitivity (94.97% and 92.2%) and specificity (94.62% and 92.1%) results.
- Committee members highlighted several of the same concerns raised with Measure #3087, but did not discuss them in any detail; these include, the omission of exclusions and as with screening, the variability of treatment protocols for malnutrition across hospitals.
- The Committee considered whether to suspend voting on reliability until the consensus not reached issues on Evidence were resolved; ultimately, the Committee decided to proceed with a vote.

3. Feasibility: H-1; M-15; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- This measure is specified for use in EHRs.
- A feasibility assessment rating the feasibility in three different EHRs is included in the submission.
- The measure was tested in in two hospital EHR systems.
- The Committee raised concern about the number of hospital EHR systems used to test the measure.

4. Usability and Use: H-0; M-14; L-3; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- This measure is currently used in the Academy of Nutrition & Dietetics and Avalere Health – Malnutrition Quality Improvement Initiative. Both organizations are working with leading hospitals and health systems, as well as with other national stakeholders, in implementing a Malnutrition Quality Improvement Demonstration and Learning Collaborative focused on reducing clinical practice variability in malnutrition care through the implementation of a standardized toolkit, which includes the collection of data on malnutrition care provided in the inpatient setting for use in internal quality improvement; initiative involves six medium – large hospitals and health systems across the country representing six different states and thousands of patients.
 - This measure is intended for submission to the Centers for Medicare & Medicaid Services Measures Under Consideration pathway for the Inpatient Quality Reporting Program. The measure steward is also working with the Joint Commission for consideration as part of its accreditation measures. The measure steward is seeking NQF endorsement in anticipation of this submission.
-

5. Related and Competing Measures

- 3087: Completion of a Malnutrition Screening within 24 hours of Admission
 - 3089: Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment
 - 3090: Appropriate Documentation of a Malnutrition Diagnosis
 - The developer states that all four measures are harmonized.
-

Standing Committee Recommendation for Endorsement: Y-5; N-9

6. Public and Member Comment

Comments received:

- NQF received thirty-nine comments from 23 organizations for measure #3088. As with #3078, the comments were largely repetitive and many references presented were included in the original measure submission. Many of the references included in the comments were included in the original measure submission and addressed findings that malnourished patients have increased lengths of stays, increased mortality, and other adverse health outcomes but were not specific to the measure foci (screening, completion of assessment, care plan).

Committee response:

- The guidelines cited by the developer are based on three individual trials, and among those three trials were inconsistencies in the very limited evidence. Though the developer noted it provided several studies looking at the impact of quality improvement programs focused on nutrition and malnutrition, we note that the quantity, quality, and consistency of the evidence to address the measure construct is important. There was clear support from many commenters, but the comments were largely repetitive, and the additional information did not provide new evidence directly addressing the measure’s focus to directly link the completion of a malnutrition assessment to improved outcomes.

3089 Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment

[Submission](#) | [Specifications](#)

Description: A nutrition care plan for those patients who are found to be malnourished based on a completed nutrition assessment with findings of malnutrition

Numerator Statement: Patients with a nutrition care plan documented in the patient's medical record. Care plan components include, but are not limited to: Completed assessment results; data and time stamp; treatment goals; prioritization based on treatment severity; prescribed treatment/intervention; identification of members of the Care Team, timeline for patient follow-up

Denominator Statement: Patients from the initial population with completed nutrition assessment documented in their medical record with findings of malnutrition.

Exclusions: Patients with a length of stay of <24 hours and patients who left against medical advice should be excluded from the measure denominator due to their very short inpatient stay.

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

Data Source: Electronic Clinical Data: Electronic Health Record

Measure Steward: Avalere Health/Academy of Nutrition & Dietetics

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-1; M-14; L-0; I-1**; 1b. Performance Gap: **H-1; M-11; L-1; I-2**

Rationale:

- This new, process eMeasure is supported by 2011 American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) guidelines that recommend nutrition support intervention for patients identified by screening and assessment as at risk for malnutrition or malnourishment. This evidence received a Grade C.
- The developer presented findings from a 2009 Cochrane Review, which included several trials supporting the supplement or nutrition support intervention; however, the findings did not show differences in outcomes.
- Three additional studies are reported published since the guidelines that relate nutrition plans to outcomes.
- The only performance data provided by the developer is from the Netherlands, where researchers assessed 395 patients to determine if they were provided appropriate malnutrition care after being identified as at-risk for malnutrition via nutrition screening. With regard to appropriate nutritional intervention for malnourished patients, when a dietitian was consulted during a malnourished patient's case, 80.6% of patients were provided additional feeding and/or vitamin supplements compared to 13.2% and 27.9% respectively by medical doctors.

- An evidence synthesis prepared for the Agency for Healthcare Research and Quality (AHRQ) found that older African American patients as well as older Hispanic women were at a higher risk of malnutrition compared to Caucasian patients.
- One Committee member asked why the developer did not cite more up-to-date data to support the evidence. The developer noted that recent evidence has not been systematically reviewed.

2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **M-10; L-5; I-0**; 2b. Validity: **M-8; L-6; I-0**

Rationale:

- All components in the measure logic of the submitted eMeasure are represented using the Health Quality Measures Format (HQMF) and Quality Data Model (QDM).
- The submitted eMeasure specifications use existing value sets, which are used within the measure, published within the Value Set Authority Center (VSAC), and are available for public use; however, Avalere has yet to complete purpose statements for each of their value sets.
- The measure was tested in two sites using three electronic health record (EHR)-systems, indicating that the measure logic works correctly and is calculating an appropriate metric for this measure.
- The submission contains a feasibility assessment that addresses data element feasibility and follow-up. The data availability, standardization and impact on workflow all have scores nearing the 3.0 range, with future availability of elements well-described in the measure submissions form.
- The developer assessed reliability at data element level using inter-rater reliability between chart abstractors in two sites for two data elements. 200 charts were assessed at both sites.
- One Committee member noted that the Kappa statistics at both sites were lower most likely because of the small sample size. For example, for the data element “nutrition care plan documented” the percent agreement at site 1 and 2 was 83% and 94%, respectively, with Kappa scores of 0.58 and 0.85.
- Validity testing was assessed in two hospitals with different EHR systems (EPIC and CERNER) in 2016.
- Data elements from manual chart abstraction were compared with data elements in the EHR. The percent agreement was 98%, with a Kappa score of 0.96, and (0.93-0.97) within the 95% confidence interval.
- The developer states that the overall summary of the results from validity testing of the specific data elements to be incorporated into this measure denominator demonstrated near perfect chance-adjusted agreement rates for the electronically extracted data element (Nutrition Assessment) once the excluded cases were removed from the calculation. However, a poorer validity result with the chart abstracted data element representing the numerator criteria (nutrition care plan documented) was evident. Although the specificity for the nutrition care plan data element was strong, the sensitivity suffered due to disagreement between the chart abstractors.
- One Committee member asked if hospice patients are excluded from the measure. The developer confirmed that hospice, discharge against medical advice, and length of stay under 24 hours are all excluded from the measure.

- During the public commenting period, several commenters cited an AHRQ statistical brief that was released after the Committee’s in-person meeting in September 2016. The brief characterizes hospital stays involving malnutrition. On the post-comment call, A few Committee members mentioned that their concerns had been addressed by the AHRQ brief.
- It also was noted that the exclusions were less of an issue on this measure than on #3087 and #3088. One Committee member, however, expressed continued concern over the exclusions not including patients on hospice, who refused referral or had complications.
- It was also noted that the 2008 paper that was used to cite a performance gap found that patients who received intervention (getting feedings or vitamins) did not result in any difference and improve clinical outcomes.
- Concern was also raised about using the EHR to extract the many plan of care data components and skepticism raised about EHRs’ ability to do this. Another Committee member noted, however, that the developer was working hard on the ability to get more information from SNOMED and LOINC and those efforts were moving forward.
- The Committee re-voted on Validity, but the measure did not pass. However, given that quorum was lost prior to voting on this measure and the outcome during the post-comment call was such that the additional votes might have meant passing the criterion, the Committee members also voted on Overall Suitability for Endorsement (Y-10; N-4). Despite this vote, the measure still did not pass Validity with the additional votes. Therefore, the measure does not pass and is not recommended for endorsement.

3. Feasibility: H-5; M-9; L-2; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- This measure is specified for use in EHRs.
- A feasibility assessment is included in the submission rating.
- Feasibility was tested in two different EHR systems, within two hospital EHR systems.

4. Usability and Use: H-2; M-11; L-2; I-1

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The developer reports that the Academy of Nutrition & Dietetics and Avalere Health are working with leading hospitals and health systems to implement a Malnutrition Quality Improvement Demonstration and Learning Collaborative focused on reducing clinical practice variability in malnutrition care through the implementation of a standardized toolkit. This would include the collection of data on malnutrition care provided in the inpatient setting for use in internal quality improvement. The initiative involves six medium- large hospitals and health systems across the country representing six different states and thousands of patients.
- This new measure is planned for submission to the Centers for Medicare & Medicaid Services Measures Under Consideration pathway for the Inpatient Quality Reporting Program. The measure steward is also working with The Joint Commission (TJC) for consideration as 1 of the TJC’s accreditation measures.

5. Related and Competing Measures

- 3087: Completion of a Malnutrition Screening within 24 hours of Admission
- 3088: Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening
- 3090: Appropriate Documentation of a Malnutrition Diagnosis
- The developer is the steward for all four measures and states that they are harmonized.

Standing Committee Recommendation for Endorsement: Y-10; N-4

- The Committee re-voted on Overall Suitability for Endorsement, given that quorum was lost prior to voting on this measure and the outcome during the post-comment call was such that the additional votes might have meant passing the criterion. The measure did not pass Validity, a must-pass criterion with the additional votes. Therefore, the measure did not pass and is not recommended for endorsement.

6. Public and Member Comment

Comments received:

- Measure #3089 received 30 comments from 18 organizations/individuals.
- Commenters and the developer recommend the Committee advance the measure. None of the comments received address the Committee’s concerns about the omission of exclusions.
- Regarding concerns about variability, one of the organizations (measure steward) (Hogle, Academy of Nutrition & Dietetics on behalf of Informatics & Interoperability Committees) noted that its committees are working to ensure that terms from the Academy’s Nutrition Care Processes (NCP) are mapped to clinical terminologies such as SNOMED-CT® and LOINC®. The comment notes, “upon malnutrition screening and appropriate assessment of at-risk patients, the nutrition intervention is developed using the NCP. Use of appropriate malnutrition language and terminologies (via the mapping of eNCPT to clinical and/or reimbursement terminologies), the intervention can be included in the electronic Care Plan. Selection of appropriate terminology possible for a problem-etiology-signs/symptoms documentation allows for structured coded data which is consistent with other areas of an EHR.”

Committee Response:

- Though there was support for the measure from commenters, as with the other nutrition measures, we are concerned that the denominator excludes patients admitted to hospice care, who refused referrals, were discharged against medical advice, or had complications—although a few of us did feel the exclusions might be less of an issue with this measure. Some of us also feel the September 2016 AHRQ brief documenting the problem of malnutrition in hospitalized patients also address some concerns for this measure. On the other hand, we noted that a 2008 paper used by the developer to document a performance gap found that patients who received intervention (getting feedings or vitamins) did not have improved clinical outcomes. We are also concerned about the capacity of EHRs to extract the many plan of care data components and skepticism, though we understand the developer is working to get more information in standardized formats. We emphasize that we recognize that nutritional status is an important area to be addressed by quality measurement.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-5; N-10

- **Decision:** The CSAC did not endorse this measure and overturned the Standing Committee's decision because the measure did not pass the Validity criterion, which is a must-pass criteria for NQF endorsement.

8. Appeals

- No Appeals received.

3090 Appropriate Documentation of a Malnutrition Diagnosis

[Submission](#) | [Specifications](#)

Description: Appropriate documentation of a malnutrition diagnosis for those patients who are found to be malnourished based on a nutrition assessment.

Numerator Statement: Patients with a documented diagnosis of malnutrition.

Denominator Statement: Patients age 65 years and older admitted to inpatient care who have a completed nutrition assessment documented in their medical record with a finding of malnutrition.

Exclusions: Patients with a length of stay of <24 hours should be excluded from the measure denominator due to their very short inpatient stay, and the length of time typically required for the full nutrition care process (screening and assessment) to be implemented.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

Data Source: Electronic Clinical Data : Electronic Health Record

Measure Steward: Avalere Health/Academy of Nutrition & Dietetics

STANDING COMMITTEE MEETING [09/12/2016-09/13/2016]

1. Importance to Measure and Report: The measure failed to meet the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-5; L-4; I-7**; 1b. Performance Gap: **H-X; M-X; L-X; I-X**

Rationale:

- The developer for this new eMeasure presented data showing patients who are malnourished while hospitalized have an increased risk of complications, readmissions, and longer lengths of stays.
- The developer presented a diagram of the relationships of processes of care to patient outcomes. However, this measure -"documentation of malnutrition diagnosis in patients found to be malnourished" is not 1 of the processes indicated on the diagram.
- Furthermore, the evidence provided addresses nutrition support for patients that are malnourished.

- The Committee raised a number of issues, including: unclear definition of “malnutrition and how it is captured; no disparities data presented; and application of the measure to a broader population (>18 years) than is recommended in the guideline (e.g., elderly).
- The developer noted the disconnect between people who are being screened at risk for malnutrition and the documentation of the diagnosis of malnutrition, and even more significant disconnect in documenting a diagnosis of malnutrition. The developer added that there is evidence to indicate that a diagnosis of malnutrition can be successfully performed and when that is done, survival improves and costs are decreased in the hospitalized patient population.
- The Committee acknowledged the importance assessing malnutrition but was concerned that there is not sufficient evidence to support the process of documenting that diagnosis is linked to improved outcomes. The measure did not pass the Evidence criterion.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-X; M-X; L-X; I-X**; 2b. Validity: **H-X; M-X; L-X; I-X**

Rationale:

3. Feasibility: H-X; M-X; L-X; I-X

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

4. Usability and Use: H-X; M-X; L-X; I-X

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

5. Related and Competing Measures

- This measure directly competes with [NQF # and Title] [Description]. [Summarize the related/competing measure issue here, and the disposition of it]

OR

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-X; N-X

Rationale

- Prior to the post-comment call, the developer submitted a reconsideration request. The Committee voted not to reconsider the measure.(Y-3; N-11)

6. Public and Member Comment

Comments received:

- NQF received 30 comments addressed to measure 3090. These comments were in line with the wealth of comments received on measure #3087, #3088, and #3089. The references included are largely repetitive and offer no additional information than what is found in the measure submission.

Measures Withdrawn from Consideration

Twenty-one measures previously endorsed by NQF have not been re-submitted for maintenance of endorsement or have been withdrawn during the endorsement evaluation process. One measure was withdrawn prior to the Committee’s evaluation.

Measure	Reason for withdrawal
0024 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Maintenance endorsement deferred; USPTF Guidelines being updated.
0029 Physical Activity in Older Adults (PAO)	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.
0034 Colorectal Cancer Screening (CCS)	Maintenance endorsement deferred; USPTF Guidelines being updated.
0043: Pneumococcal Vaccination Status for Older Adults (PNU)	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.
0522 Influenza Immunization Received for Current Flu Season (Home Health)	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.
0525 Pneumococcal Polysaccharide Vaccine (PPV) Ever Received (Home Health)	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.
0682 Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)	Developer submitted request to NQF with intent not to submit, therefore NQF has removed endorsement.
0683 Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Long-Stay)	Developer submitted request to NQF with intent not to submit, therefore NQF has removed endorsement.
0717 Number of School Days Children Miss Due to Illness	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.
0719 Children Who Receive Effective Care Coordination of Healthcare Services When Needed	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.
0720 Children Who Live in Communities Perceived as Safe	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.
0721 Children Who Attend Schools Perceived as Safe	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.

Measure	Reason for withdrawal
0724 Measure of Medical Home for Children and Adolescents	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.
1333 Children Who Receive Family-Centered Care	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.
1340 Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.
1346 Children Who Are Exposed To Secondhand Smoke Inside Home	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.
1348 Children Age 6-17 Years who Engage in Weekly Physical Activity	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.
1349 Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.
1653 Pneumococcal Immunization	Developer submitted request to NQF with intent not to submit, therefore NQF has removed endorsement.
1999 HIV Late Diagnosis	Developer did not resubmit this measure for maintenance review, therefore NQF has removed endorsement.
3062 Hypertension Screening for Children Who Are Overweight or Obese	Measure withdrawn at request of developer to conduct additional testing.

¹ Please refer to the [Committee memo](#) for additional information related to the references.

² Please refer to the [Committee memo](#) for additional information related to the references.

Appendix B: NQF Health and Well-Being Portfolio and Related Measures¹

Health-Related Behaviors and Practices to Promote Healthy Living

Measure Number	Measure Title
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Community-Level Indicators of Health and Disease

Measure Number	Measure Title
0272	Diabetes, short-term complications (PQI 1)
0274	Diabetes, long-term complications (PQI 3)
0277	Congestive Heart Failure Admission Rate (PQI 8)
0279	Bacterial [Community-Acquired] Pneumonia Admission Rate (PQI 11)
0280	Dehydration Admission Rate (PQI 10)
0281	Urinary infections (PQI 12)
0285	Lower extremity amputations among patients with diabetes (PQI 16)
0638	Uncontrolled Diabetes Admission Rate (PQI 14)
0727	Gastroenteritis Admission Rate (pediatric)
0728	Asthma Admission Rate (pediatric)
2020	Adult Current Smoking Prevalence

Modifiable Social, Economic, and Environmental Determinants of Health

Measure Number	Measure Title
0718	Children Who Had Problems Obtaining Referrals When Needed
0723	Children Who Have Inadequate Insurance Coverage For Optimal Health
1330	Children With a Usual Source for Care When Sick
1332	Children Who Receive Preventive Medical Visits
1337	Children With Inconsistent Health Insurance Coverage in the Past 12 Months
1392	Well-Child Visits in the First 15 Months of Life

Primary Prevention and/or Screening

Measure Number	Measure Title
0032	Cervical Cancer Screening
0034	Colorectal Cancer Screening
0038	Childhood Immunization Status
0039	Flu Shots for Adults Ages 50 and Over
0041	Influenza Immunization
0226	Influenza Immunization in the ESRD Population (Facility Level)

Measure Number	Measure Title
0227	Influenza Immunization
0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
0431	Influenza Vaccination Coverage Among Healthcare Personnel
0629	Male Smokers or Family History of Abdominal Aortic Aneurysm (AAA) - Consider Screening for AAA
0680	Percent of Nursing Home Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)
0681	Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (Long-Stay)
1392	Well-Child Visits in the First 15 Months of Life
1407	Immunizations by 13 years of age
1448	Developmental Screening in the First Three Years of Life
1516	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
1659	Influenza Immunization
1959	Human Papillomavirus Vaccine for Female Adolescents
2372	Breast Cancer Screening

Oral Health

Measure Number	Measure Title
0280	Dehydration Admission Rate (PQI 10)
1334	Children Who Received Preventive Dental Care
1335	Children Who Have Dental Decay or Cavities
2508	Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk
2509	Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk
2511	Utilization of Services, Dental Services
2517	Oral Evaluation, Dental Services
2528	Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services
2689	Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children
2695	Follow-Up after Emergency Department Visit by Children for Dental Caries

¹ NQF has assigned some measures related to health and well-being to other projects, primarily to manage the size of the portfolio and take advantage of technical expertise. For example, the endocrine project reviewed measures that assess osteoporosis screening.

Appendix C: Health and Well-Being Measures Under Review—Use in Federal Programs

NQF #	Title	Federal Programs: Finalized as of September 2016
0032	Cervical Cancer Screening (CCS)	Medicaid, Medicare Physician Quality Reporting System (PQRS), Physician Feedback/Quality and Resource Use Reports (QRUR), Physician Value-Based Payment Modifier (VBM), Qualified Health Plan (QHP) Quality Rating System (QRS)
0038	Childhood Immunization Status	Merit-Based Incentive Payment System (MIPS) Program, Medicaid, Physician Value-Based Payment Modifier (VBM), Physician Feedback/Quality and Resource Use Reports (QRUR), Medicare Physician Quality Reporting System (PQRS), Qualified Health Plan (QHP) Quality Rating System (QRS)
0039	Flu Shots for Adults Ages 50 and Over	Qualified Health Plan (QHP) Quality Rating System (QRS), Medicaid
0041	Influenza Immunization	Medicare Shared Savings Program (MSSP), Merit-Based Incentive Payment System (MIPS) Program, Physician Value-Based Payment Modifier (VBM), Physician Feedback/Quality and Resource Use Reports (QRUR), Physician Compare, Medicare Physician Quality Reporting System (PQRS)
0226	Influenza Immunization in the ESRD Population (Facility Level)	No federal program usage specified for this measure.
0431	Influenza Vaccination Coverage Among Healthcare Personnel	Ambulatory Surgical Center Quality Reporting, Home Health Value Based Purchasing, End-Stage Renal Disease Quality Incentive Program (QIP), Hospital Compare, Hospital Inpatient Quality Reporting, Hospital Outpatient Quality Reporting, Inpatient Psychiatric Facility Quality Reporting, Inpatient Rehabilitation Facility Quality Reporting, Long-Term Care Hospital Quality Reporting, Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting
0680	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)	Inpatient Rehabilitation Facility Quality Reporting, Long-Term Care Hospital Quality Reporting

NQF #	Title	Federal Programs: Finalized as of September 2016
0681	Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)	No federal program usage specified for this measure.
1659	Influenza Immunization	Hospital Compare, Hospital Inpatient Quality Reporting, Hospital Value-Based Purchasing, Inpatient Psychiatric Facility Quality Reporting
2828	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Medicare Physician Quality Reporting System (PQRS), Medicare Shared Savings Program (MSSP), Physician Compare, Physician Feedback/Quality and Resource Use Reports (QRUR), Physician Value-Based Payment Modifier (VBM)
0421:3039	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Medicare Shared Savings Program (MSSP), Merit-Based Incentive Payment System (MIPS) Program, Physician Value-Based Payment Modifier (VBM), Physician Feedback/Quality and Resource Use Reports (QRUR), Physician Compare, Medicare Physician Quality Reporting System (PQRS)
3059	One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	No federal program usage specified for this measure.
3060	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	No federal program usage specified for this measure.
3061	Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection	No federal program usage specified for this measure.
3067	Human Immunodeficiency Virus (HIV) Infection Screening	No federal program usage specified for this measure.
3070	Preventive Care and Screening: Influenza Immunization	Medicare Physician Quality Reporting System (PQRS), Meaningful Use Stage 2 (EHR Incentive Program)
3071	Follow-up Referral after Positive Developmental Screen	No federal program usage specified for this measure.

NQF #	Title	Federal Programs: Finalized as of September 2016
3086	Population Level HIV Viral Load Suppression	HIV Surveillance Supplemental Report-- Monitoring Selected National HIV Prevention and Care Objectives by Using HIV Surveillance Data United States and 6 Dependent Areas, HIV/AIDS Strategy (NHAS)
3087	Completion of a Malnutrition Screening within 24 hours of Admission	No federal program usage specified for this measure.
3088	Completion of Nutrition Assessment for Patients Identified as At-Risk for Malnutrition	No federal program usage specified for this measure.
3089	Nutrition Care Plan for Patients Identified as Malnourished	No federal program usage specified for this measure.
3090	Appropriate Documentation of a Malnutrition Diagnosis	No federal program usage specified for this measure.

Appendix D: Project Standing Committee and NQF Staff

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Appendix E: Measure Specifications

0032 Cervical Cancer Screening (CCS)

STEWARD

National Committee for Quality Assurance

DESCRIPTION

Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every 3 years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

TYPE

Process

DATA SOURCE

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

No data collection instrument provided Attachment 0032_CCS_Value_Sets.xlsx

LEVEL

Health Plan, Integrated Delivery System

SETTING

Ambulatory Care : Clinician Office/Clinic

NUMERATOR STATEMENT

The number of women who were screened for cervical cancer.

NUMERATOR DETAILS

ADMINISTRATIVE SPECIFICATION

The number of women who were screened for cervical cancer, as identified in steps 1 and 2 below.

Step 1: Identify women 24-64 years of age as of the end of the measurement year who had cervical cytology (Cervical Cytology Value Set) during the measurement year or the two years prior to the measurement year.

Step 2: From the women who did not meet Step 1 criteria, identify women 30-64 years of age as of the end of the measurement year who had cervical cytology (Cervical Cytology Value Set) and a human papillomavirus (HPV) test (HPV Tests Value Set) with service dates four or less days apart during the measurement year or the four years prior to the measurement year AND who were 30 years or older on the date of both tests. For example, if the service date for cervical

cytology was December 1 of the measurement year, then the HPV test must include a service date on or between November 27 and December 5 of the measurement year.

Step 3: Sum the events from Step 1 and Step 2 to obtain the rate.

- See corresponding Excel document for the Cervical Cytology Value Set

- See corresponding Excel document for the HPV Tests Value Set

MEDICAL RECORD SPECIFICATION

Step 1: Identify women 24-64 years of age as of the end of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year.

Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology was performed.

- The result or finding

Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

NOTE: Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.

Step 2: From the women who did not meet Step 1 criteria, identify women 30-64 years of age as of the end of the measurement year who had cervical cytology and a human papillomavirus (HPV) test on the same date of service during the measurement year or the four years prior to the measurement year AND who were 30 years or older as of the date of testing.

Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology and the HPV test were performed. The cervical cytology and HPV test must be from the same data source.

- The results or findings.

Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

In administrative data, there is flexibility in the date of service to allow for a potential lag in claims. In the medical record data, an HPV test performed without accompanying cervical cytology on the same date of service does not constitute co-testing and does not meet criteria for inclusion in this rate.

NOTE: Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.

Step 3: Sum the events from Step 1 and Step 2 to obtain the rate.

DENOMINATOR STATEMENT

Women 24-64 years of age as of the end of the measurement year.

DENOMINATOR DETAILS

Use administrative data to identify all women 24-64 years of age as of the end of the measurement year.

EXCLUSIONS

Exclude: Women who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during their medical history through the end of the measurement year.

EXCLUSION DETAILS

ADMINISTRATIVE SPECIFICATION:

Look as far back as possible in the patient's history for evidence of hysterectomy through the end of the measurement year. - See corresponding Excel document for the Absence of Cervix Value Set.

MEDICAL RECORD SPECIFICATION:

Evidence of a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the patient's history through the end of the measurement year.

Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. The following also meet criteria:

- Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy".

- Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening.

Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

None

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1: Calculate the eligible population of women following the instructions in the denominator details listed in section S.9.

Step 2: Remove the exclusions identified in section S.10.

Step 3: Calculate the numerator for Rate 1 following the instructions in the numerator details listed in section S.6.

Step 4: Divide the numerator from Step 3 by the denominator from Step 2 to determine Rate 1.

Step 5: Calculate the numerator for Rate 2 following the instructions in the numerator details listed in section S.6.

Step 6: Divide the numerator from Step 5 by the denominator from Step 2 to determine Rate 2.
No diagram provided

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5.1 Identified measures: 0579 : Annual cervical cancer screening or follow-up in high-risk women

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: The numerator for both measures focuses on women who had cervical cancer screening during the year, but #0579 focuses on a denominator of high-risk patients and is used in a surveillance strategy. The NCQA measure is intended to measure cervical cancer screening in the general population. Exclusions are aligned across these measures.

5b.1 If competing, why superior or rationale for additive value: NA

0038 Childhood Immunization Status (CIS)

STEWARD

National Committee for Quality Assurance

DESCRIPTION

Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and a combination rate.

TYPE

Process

DATA SOURCE

Administrative claims, Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data : Registry This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

No data collection instrument provided Attachment 0038_CIS_Value_Sets.xlsx

LEVEL

Health Plan, Integrated Delivery System

SETTING

Ambulatory Care : Clinician Office/Clinic

NUMERATOR STATEMENT

Children who received the recommended vaccines by their second birthday.

NUMERATOR DETAILS

Children with evidence of the following.

For MMR, hepatitis B, VZV and hepatitis A , count any of the following:

- evidence of the antigen or combination vaccine, or
- documented history of the illness, or
- a seropositive test result for each antigen

For DtaP, IPV, HiB, pneumococcal conjugate, rotavirus and influenza, count only:

- Evidence of the antigen or combination vaccine.

For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the organization must find evidence of all of the antigens.

ADMINISTRATIVE

- DTaP: At least four DTaP vaccinations (DTaP Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

(See corresponding Excel document for the DtaP Vaccine Administered Value Set)

- IPV: At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

(See corresponding Excel document for the Inactivated Polio Vaccine (IPV) Administered Value Set)

- MMR: Any of the following on or before the child's second birthday meet criteria:

- At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Vaccine Administered Value Set).

- At least one measles and rubella vaccination (Measles/Rubella Vaccine Administered Value Set) and at least one mumps vaccination or history of the illness (Mumps Vaccine Administered Value Set; Mumps Value Set) on the same date of service or on different dates of service.

- At least one measles vaccination or history of the illness (Measles Vaccine Administered Value Set; Measles Value Set) and at least one mumps vaccination or history of the illness (Mumps Vaccine Administered Value Set; Mumps Value Set) and at least one rubella vaccination or history of the illness (Rubella Vaccine Administered Value Set; Rubella Value Set) on the same date of service or on different dates of service.

Note: General Guideline 39 (i.e., the 14-day rule) does not apply to MMR.

(See corresponding Excel document for the appropriate value sets)

- HiB: At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

(See corresponding Excel document for the Haemophilus Influenzae Type B (HiB) Vaccine Administered Value Set)

- Hepatitis B: Any of the following on or before the child's second birthday meet criteria:

- At least three hepatitis B vaccinations (Hepatitis B Vaccine Administered Value Set), with different dates of service.

- One of the three vaccinations can be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the member's date of birth

is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.

- History of hepatitis illness (Hepatitis B Value Set).

(See corresponding Excel document for the appropriate value sets)

- VZV: Either of the following on or before the child's second birthday meet criteria:

- At least one VZV vaccination (Varicella Zoster (VZV) Vaccine Administered Value Set), with a date of service on or before the child's second birthday.

- History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set).

(See corresponding Excel document for the appropriate value sets)

- Pneumococcal conjugate: At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

(See corresponding Excel document for the Pneumococcal Conjugate Vaccine Administered Value Set)

- Hepatitis A: Either of the following on or before the child's second birthday meet criteria:

- At least one hepatitis A vaccination (Hepatitis A Vaccine Administered Value Set), with a date of service on or before the child's second birthday.

- History of hepatitis A illness (Hepatitis A Value Set).

(See corresponding Excel document for the above value sets)

- Rotavirus: Any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth.

- At least two doses of the two-dose rotavirus vaccine (Rotavirus Vaccine [2 Dose Schedule] Administered Value Set) on different dates of service.

- At least three doses of the three-dose rotavirus vaccine (Rotavirus Vaccine [3 Dose Schedule] Administered Value Set) on different dates of service.

- At least one dose of the two-dose rotavirus vaccine (Rotavirus Vaccine [2 Dose Schedule] Administered Value Set) and at least two doses of the three-dose rotavirus vaccine (Rotavirus Vaccine [3 Dose Schedule] Administered Value Set), all on different dates of service.

(See corresponding Excel document for the appropriate value sets)

- Influenza: At least two influenza vaccinations (Influenza Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 6 months (180 days) after birth.

(See corresponding Excel document for the Influenza Value Set)

- Combination rates: Calculate the following rates for Combination 2- Combination 10

- Combination 2 – DTaP, IPV, MMR, HiB, HepB, VZV

- Combination 3 - DTaP, IPV, MMR, HiB, HepB, VZV, PCV

- Combination 4 - DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA

- Combination 5 - DTaP, IPV, MMR, HiB, HepB, VZV, PCV, RV

- Combination 6 - DTaP, IPV, MMR, HiB, HepB, VZV, PCV, Influenza

- Combination 7 - DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV

- Combination 8 - DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, Influenza

- Combination 9 - DTaP, IPV, MMR, HiB, HepB, VZV, PCV, RV, Influenza
- Combination 10 - DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, Influenza

MEDICAL RECORD

For immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from one of the following:

- A note indicating the name of the specific antigen and the date of the immunization.
- A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.

For documented history of illness or a seropositive test result, there must be a note indicating the date of the event, which must have occurred by the member's second birthday.

Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator only for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth). A note that the "member is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

Immunizations documented using a generic header or "DTaP/DTP/DT" can be counted as evidence of DTaP. The burden on organizations to substantiate the DTaP antigen is excessive compared to a risk associated with data integrity.

For rotavirus, if documentation does not indicate whether the two-dose schedule or three-dose schedule was used, assume a three-dose schedule and find evidence that three doses were administered.

DENOMINATOR STATEMENT

Children who turn 2 years of age during the measurement year.

DENOMINATOR DETAILS

Children who turn 2 years of age during the measurement year.

EXCLUSIONS

Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.

EXCLUSION DETAILS

Any of the following on or before the member's second birthday meet exclusion criteria:

Any particular vaccine

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set).

DTaP

- Encephalopathy (Encephalopathy Due To Vaccination Value Set) with a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set).

MMR, VZV and influenza

- Immunodeficiency (Disorders of the Immune System Value Set).
- HIV (HIV Value Set).

- Lymphoreticular cancer, multiple myeloma or leukemia (Malignant Neoplasm of Lymphatic Tissue Value Set).

- Anaphylactic reaction to neomycin.

IPV

- Anaphylactic reaction to streptomycin, polymyxin B or neomycin.

Hepatitis B

- Anaphylactic reaction to common baker's yeast.

See corresponding Excel document for the appropriate value sets.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Reported by Commercial and Medicaid plans.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1. Determine the eligible population. The eligible population is all children who satisfy the criteria in section S.9. above.

Step 2. Identify children who meet numerator criteria described in section S.6.

Step 3. Calculate the denominator: for children who do not show a positive numerator event, remove from the eligible population children identified as having a contraindication for a vaccine (exclusion) as specified in section S.10.

Step 4. Calculate the rate by dividing the number of children in step 2 (numerator) by the number of children in step 3 (denominator). No diagram provided

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5.1 Identified measures: 0475 : Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge

0479 : Birth dose of hepatitis B vaccine and hepatitis B immune globulin for newborns of hepatitis B surface antigen (HBsAg) positive mothers

0041 : Preventive Care and Screening: Influenza Immunization

1659 : Influenza Immunization

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Please see 5b.1.

5b.1 If competing, why superior or rationale for additive value: 5a.2.

Childhood Immunization Status (NQF #0038) and Birth dose of hepatitis B vaccine and hepatitis B immune globulin for newborns of HBsAg-positive mothers (NQF #0479) both address hepB vaccination of children. However, NQF #0479 focuses on newborns of HBsAg-positive mothers, a high-risk subset of infants, and assesses receipt of the birth dose of hepB vaccine. Childhood Immunization Status (#0038) focuses on all children up to age two and assesses receipt of the full three-dose hepB vaccination series, which may include the newborn dose. NQF #0038 also

assesses receipt of all vaccines recommended by the Advisory Committee on Immunization Practices in addition to hepB.

Childhood Immunization Status (NQF #0038) and HepB Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge (NQF #0475) both address hepB vaccination of children. NQF #0475 assesses whether newborns received hepB prior to leaving the hospital/birthing facility. Childhood Immunization Status (#0038) focuses on all children up to age two and assesses receipt of the full three-dose hepB vaccination series, which may include the newborn dose. NQF #0038 also assesses receipt of all vaccines recommended by the Advisory Committee on Immunization Practices in addition to hepB.

Childhood Immunization Status (NQF #0038) and Influenza Immunization (NQF #0041) both address influenza vaccination. NQF #0041 focuses specifically on influenza vaccination in children and adults age 6 months and older and is specified at the clinician level. Childhood Immunization Status (#0038) focuses on children up to age two and assesses receipt of at least two influenza vaccines by the child's second birthday and is specified at the health plan level. The measure numerator intents align, and both measures do not apply to children under age 6 months, as this vaccine is not recommended in those age groups. NQF #0038 also assesses receipt of all vaccines recommended by the Advisory Committee on Immunization Practices in addition to hepB.

Childhood Immunization Status (NQF #0038) and Influenza Immunization (NQF #1659) both address influenza vaccination. NQF #1659 focuses on an inpatient population and includes children and adults age 6 months and older and is specified at the hospital/acute care facility level. Childhood Immunization Status (#0038) focuses on children up to age two and assesses receipt of at least two influenza vaccines by the child's second birthday and is specified at the health plan level. The measure numerator intents align, and both measures do not apply to children under age 6 months, as this vaccine is not recommended in those age groups. NQF #0038 also assesses receipt of all vaccines recommended by the Advisory Committee on Immunization Practices in addition to hepB.

5b.1.

This measure is the only NQF-endorsed measure to evaluate the full spectrum of vaccinations children up to age two years should receive. Other measures evaluate individual vaccines, such as hepatitis B vaccination and influenza vaccine, and some target specific populations, such as newborns of HBsAG-positive mothers.

0039 Flu Vaccinations for Adults Ages 18 and Older

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure is collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, and commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.

TYPE

Process

DATA SOURCE

Patient Reported Data/Survey This survey can be administered by mail, telephone, or internet. It is offered in English and Spanish. Organizations may use their own translation of the survey with approval of NCQA.

Available at measure-specific web page URL identified in S.1 No data dictionary

LEVEL

Health Plan, Integrated Delivery System

SETTING

Ambulatory Care : Clinician Office/Clinic, Home Health, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Pharmacy, Ambulatory Care : Urgent Care

NUMERATOR STATEMENT

This measure is reported as two rates:

Flu Vaccination for Adults age 18-64 – Respondents to the Medicaid or commercial CAHPS survey who report having received an influenza vaccination since July of the previous year.

Flu Vaccination for Adults age 65+ - Respondents to the Medicare CAHPS survey who report having received an influenza vaccination since July of the previous year.

NUMERATOR DETAILS

Flu Vaccinations for Adults Ages 18-64 – CAHPS respondents answering “yes” to the question: “Have you had either a flu shot or flu spray in the nose since July 1, YYYY?” where YYYY is the measurement year (e.g. 2014 for the survey fielded in 2015). Response Choices: “Yes, No, Don’t know”

Flu Vaccination for Adults Age 65 and Older – CAHPS respondents answering “yes” to the question: “Have you had a flu shot or flu spray since July 1, YYYY?” where YYYY is the measurement year (e.g. 2014 for the survey fielded in 2015). Response Choices: “Yes, No, Don’t know”

DENOMINATOR STATEMENT

Flu Vaccinations for Adults Ages 18-64 – Medicaid and Commercial CAHPS respondents age 18-64

Flu Vaccination for Adults Age 65 and Older – Medicare CAHPS respondents age 65 and older.

DENOMINATOR DETAILS

Flu Vaccination for Adults Ages 18-64 - The number of patients age 18-64 who responded “Yes” or “No” to the question “Have you had either a flu shot or flu spray in the nose since July 1, YYYY?”

Flu Vaccination for Adults Age 65 and Older – The number of patients age 65 and older who responded “Yes” or “No” to the question, “Have you had a flu shot or flu spray in the nose since July 1, YYYY?”

EXCLUSIONS

N/A

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Flu Vaccination for Adults Ages 18-64

Step 1) Identify the eligible population of Medicaid and Commercial CAHPS respondents

Step 2) Identify the denominator: Adults age 18-64 as of July 1 of the measurement year who responded “yes” or “no” to the question “Have you had either a flu shot or flu spray in the nose since July 1, YYYY?” Respondents who answer “don’t know” or have a missing response are not included in the denominator.

Step 3) Identify the numerator: Adults in the denominator who answer “yes” to the question.

Step 4) Calculate the rate as numerator/denominator

Flu Vaccination for Adults Age 65 and Older

Step 1) Identify the eligible population of Medicare CAHPS respondents

Step 2) Identify the denominator: Adults age 65 as of July 1 of the measurement year who responded “yes” or “no” to the question “Have you had a flu shot or flu spray in the nose since July 1, YYYY?” Respondents who answer “don’t know” or have a missing response are not included in the denominator.

Step 3) Identify the numerator: Adults in the denominator who answer “yes” to the question.

Step 4) Calculate the rate as numerator/denominator No diagram provided

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5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

0226 : Influenza Immunization in the ESRD Population (Facility Level)

0227 : Influenza Immunization

0041 : Preventive Care and Screening: Influenza Immunization

0431 : Influenza Vaccination Coverage Among Healthcare Personnel

0522 : Influenza Immunization Received for Current Flu Season (Home Health)

1659 : Influenza Immunization

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Measure 0039 is the only measure collected through patient survey. This measure is collected through the CAHPS 5.0 Adult Survey. We specify collecting this measure through a survey because many adult flu vaccinations are given outside of the traditional medical setting (e.g. at work or in retail flu clinics) and are therefore less likely to be documented in a medical record or claim.

5b.1 If competing, why superior or rationale for additive value: NCQA views these measures as complementary to each other; each supporting the goal of protecting the individual and the population from active influenza viruses.

0041 Preventive Care and Screening: Influenza Immunization

STEWARD

PCPI Foundation

DESCRIPTION

Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

TYPE

Process

DATA SOURCE

Electronic Clinical Data, Electronic Clinical Data : Registry Not applicable
No data collection instrument provided No data dictionary

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Other Domiciliary

NUMERATOR STATEMENT

Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

NUMERATOR DETAILS

For Registry:

NUMERATOR DEFINITION:

Previous Receipt – Receipt of the current season’s influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).

NUMERATOR GUIDANCE:

The numerator for this measure can be met by reporting either administration of an influenza vaccination or that the patient reported previous receipt of the current season’s influenza

immunization. If the performance of the numerator is not met, an eligible clinician can report a valid Denominator Exception for having not administered an influenza vaccination.

NUMERATOR SPECIFICATION:

Report one of the following options:

CPT Code for Influenza Immunization:

•90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90664, 90666, 90667, 90668, 90672, 90673, 90685, 90686, 90687, 90688

OR

Quality data code for Influenza Immunization or Prior Receipt:

•G8482: Influenza immunization administered or previously received

DENOMINATOR STATEMENT

All patients aged 6 months and older seen for a visit between October 1 and March 31

DENOMINATOR DETAILS

For Registry:

DENOMINATOR SPECIFICATION:

Age \geq 6 months

AND

At least one encounter during measurement period (CPT or HCPCS): 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, 99512, G0438, G0439

EXCLUSIONS

Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons)

Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons)

Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons)

EXCLUSION DETAILS

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or

system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure on Preventive Care and Screening: Influenza Immunization, exceptions may include medical reason(s) (eg, patient allergy); patient reason(s) (eg, patient declined); or system reason(s) for the patient not receiving influenza immunization (eg, vaccine not available). Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Additional details by data source are as follows:

For Registry:

DENOMINATOR EXCEPTION GUIDANCE:

For eligible clinicians reporting a Denominator Exception for this measure, there should be a clear rationale and documented reason for not administering an influenza immunization if the patient did not indicate previous receipt, which could include a medical reason (eg, patient allergy, other medical reason), patient reason (eg, patient declined, other patient reason), or system reason (eg, vaccination not available, other system reason). The system reason should be indicated only for cases of disruption or shortage of influenza vaccination supply.

DENOMINATOR EXCEPTION SPECIFICATION:

To report a denominator exception, report the following quality data code:

G8483: Influenza immunization was not administered for reasons documented by clinician (eg, patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons)

RISK ADJUSTMENT

No risk adjustment or risk stratification.

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, patient allergy) patient reason(s) (eg, patient declined) or system reason(s) for the patient not receiving influenza immunization (eg, vaccine not available, other system reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. No diagram provided

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5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

0226 : Influenza Immunization in the ESRD Population (Facility Level)

0039 : Flu Vaccinations for Adults Ages 18 and Older

0431 : Influenza Vaccination Coverage Among Healthcare Personnel

0522 : Influenza Immunization Received for Current Flu Season (Home Health)

1659 : Influenza Immunization

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Related measures have differing target populations from measure 0041 Preventive Care and Screening: Influenza Immunization. Measure #0041 is intended to evaluate adherence to the current recommendations of the Advisory Committee on Immunization Practices. The Committee recommends routine annual influenza vaccination for all persons aged ≥ 6 months who do not have contraindications. Measure #0039 - Flu Vaccinations for Adults ages 18 and Older focuses on the self-reported receipt of influenza vaccination among adults using the CAHPS survey. Measure #0226 – Influenza Immunization in the ESRD Population is a facility level measure focused on influenza vaccination among end stage renal disease (ESRD) patients receiving hemodialysis or peritoneal dialysis. Measure #0431 - Influenza Vaccination Coverage Among Healthcare Personnel focuses on influenza vaccination among healthcare workers. Measure #0522 Influenza Immunization Received for Current Flu Season (Home Health) evaluates influenza immunization during home health episodes of care. Measure # 0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay) applies to patients of Inpatient Rehabilitation Facilities and Long-Term Care Hospitals, and to short-stay nursing home residents. Measure #0681 - Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay) assess influenza

vaccination among long-stay nursing facility residents. Measure #1659 Influenza Immunization is limited to the assessment of influenza vaccination upon discharge from the inpatient setting.

5b.1 If competing, why superior or rationale for additive value:

0226 Influenza Immunization in the ESRD Population (Facility Level)

STEWARD

Kidney Care Quality Alliance

DESCRIPTION

Percentage of end stage renal disease (ESRD) patients aged 6 months and older receiving hemodialysis or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31 who either received, were offered and declined, or were determined to have a medical contraindication to the influenza vaccine.

TYPE

Process

DATA SOURCE

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records The necessary data elements are to be collected via the CMS CROWNWeb data repository.

No data collection instrument provided No data dictionary

LEVEL

Facility

SETTING

Dialysis Facility

NUMERATOR STATEMENT

Number of patients from the denominator who:

1. received an influenza vaccination,* documented by the provider or reported receipt from another provider by the patient (computed and reported separately);

OR

2. were assessed and offered an influenza vaccination but declined (computed and reported separately);

OR

3. were assessed and determined to have a medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, and/or bone marrow transplant within the past 6 months (<6 months prior to encounters between October 1 and March 31) (computed and reported separately).

*Only inactivated vaccine should be used in the ESRD population.

NUMERATOR DETAILS

Include in the numerator all patients from the denominator who:*

1. Received an influenza vaccination** (documented by the provider or reported receipt from another provider by the patient).
2. Were assessed and offered an influenza vaccination but declined.
3. Were assessed and were determined to have a medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, and/or bone marrow transplant within the past 6 months (<6 months prior to encounters between October 1 and March 31).

*Each of the 3 numerator subcategories are to be computed and reported separately.

**Only inactivated vaccine should be used in the ESRD population.

DENOMINATOR STATEMENT

All ESRD patients aged 6 months and older receiving hemodialysis and/or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31.

DENOMINATOR DETAILS

Include in the denominator all patients within a facility who meet the following criteria during the time from October 1 (or when the influenza vaccine became available) to March 31 of the reporting year:

1. Diagnosis = ESRD

AND

2. Primary type of dialysis = hemodialysis, home hemodialysis, continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), or nighttime intermittent peritoneal dialysis (NIPD).

AND

3. Age = \geq 6 months

EXCLUSIONS

None.

EXCLUSION DETAILS

Not applicable.

RISK ADJUSTMENT

No risk adjustment or risk stratification

Not applicable.

STRATIFICATION

Not applicable.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

DENOMINATOR

Include in the denominator all patients within a facility who meet the following criteria during the time from October 1 (or when the influenza vaccine became available) to March 31 of the reporting year:

1. Diagnosis = ESRD

AND

2. Primary type of dialysis = hemodialysis, home hemodialysis, continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), or nighttime intermittent peritoneal dialysis (NIPD)

AND

3. Age = \geq 6 months or older as of the first day of the most recent month of the reporting period. (Patient's age is or shall be determined by subtracting the patient's date of birth from the first day of the most recent month of the reporting period.)

NUMERATOR

Include in the numerator all patients from the denominator who meet the following criteria:**

1. Patient received an influenza vaccination* (documented by the provider or reported receipt from another provider by the patient);

OR

2. Patient was assessed and offered an influenza vaccination but declined;

OR

3. Patient was assessed and was determined to have a medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, and/or bone marrow transplant within the past 6 months (<6 months prior to encounters between October 1 and March 31).

*Only inactivated vaccine should be used in the ESRD population.

** Each of the 3 numerator subcategories are to be computed and reported separately. No diagram provided

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5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

0227 : Influenza Immunization

0039 : Flu Vaccinations for Adults Ages 18 and Older

0041 : Preventive Care and Screening: Influenza Immunization

0149 : Influenza vaccination

0432 : Influenza Vaccination of Nursing Home/ Skilled Nursing Facility Residents

0522 : Influenza Immunization Received for Current Flu Season (Home Health)

1659 : Influenza Immunization

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable.

5b.1 If competing, why superior or rationale for additive value: No known competing measures.

0279 Bacterial Pneumonia Admission Rate (PQI 11)

STEWARD

Agency for Healthcare Research and Quality

DESCRIPTION

Admissions with a principal diagnosis of bacterial pneumonia per 1,000 population, ages 18 years and older. Excludes sickle cell or hemoglobin-S admissions, other indications of immunocompromised state admissions, obstetric admissions, and transfers from other institutions.

TYPE

Outcome

DATA SOURCE

Administrative claims While the measure is tested and specified using data from the Healthcare Cost and Utilization Project (HCUP) (see section 1.1 and 1.2 of the measure testing form), the measure specifications and software are specified to be used with any ICD-9-CM- or ICD-10-CM/PCS coded administrative billing/claims/discharge dataset.

Available at measure-specific web page URL identified in S.1 Attachment PQI11_Technical_Specifications_v6.1alpha_151214_v02.xlsx

LEVEL

Population : County or City

SETTING

Other All community based care

NUMERATOR STATEMENT

Discharges, for patients ages 18 years and older, with a principal ICD-9-CM or ICD-10-CM-PCS diagnosis code for bacterial pneumonia.

[NOTE: By definition, discharges with a principal diagnosis of bacterial pneumonia are precluded from an assignment of MDC 14 by grouper software. Thus, obstetric discharges should not be considered in the PQI rate, though the AHRQ QI software does not explicitly exclude obstetric cases.]

NUMERATOR DETAILS

Please see attached excel file in S.2b. for Version 6.0 specifications.

Prevention Quality Indicators technical specifications and appendices also available online at http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx. Note: The URL link currently provides Version 5.0 specifications. Version 6.0 specifications will be released publicly March 2016.

DENOMINATOR STATEMENT

Population ages 18 years and older in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.

DENOMINATOR DETAILS

The term “metropolitan area” (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs), and primary metropolitan statistical areas (PMSAs). In addition, “area” could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area, or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the QI software.

See AHRQ QI website for 2014 Population File Denominator report for calculation of population estimates embedded within AHRQ QI software programs.

http://www.qualityindicators.ahrq.gov/Downloads/Software/SAS/V50/AHRQ_QI_Population_File_V50.pdf

EXCLUSIONS

Not applicable.

EXCLUSION DETAILS

Not applicable.

RISK ADJUSTMENT

Statistical risk model

The predicted value for each case is computed using a hierarchical model (logistic regression with hospital random effect) and covariates for gender, age (in 5-year age groups). An option model is available that includes percent of households under the federal poverty level as well. Because we cannot individually observe the age and gender of each person in a counties population, we use the age and gender distribution of the county to estimate the number of “cases” in each age*gender group. The reference population used in the regression is the universe of discharges for states that participate in the HCUP State Inpatient Data (SID) for the year 2013 (combined), a database consisting of 40 states, and the U.S. Census data by county. The expected rate is computed as the sum of the predicted value for each case divided by the number of cases for the unit of analysis of interest (i.e., area). The risk adjusted rate is computed using indirect standardization as the observed rate divided by the expected rate, multiplied by the reference population rate.

Additional information on methodology can be found in the Empirical Methods document on the AHRQ Quality Indicator website (www.qualityindicators.ahrq.gov) and in the supplemental information attached.

The specific covariates for this measure are as follows:

PARAMETER	LABEL
SEX	Female
AGE	Male, Age 18-24
AGE	Male, Age 25-29
AGE	Male, Age 30-34

AGE Male, Age 35-39
 AGE Male, Age 40-44
 AGE Male, Age 45-49
 AGE Male, Age 50-54
 AGE Male, Age 55-59
 AGE Male, Age 60-64
 AGE Male, Age 65-69
 AGE Male, Age 70-74
 AGE Male, Age 75-79
 AGE Male, Age 80-84
 AGE Male, Age 85+
 AGE Female, Age 18-24
 AGE Female, Age 25-29
 AGE Female, Age 30-34
 AGE Female, Age 35-39
 AGE Female, Age 40-44
 AGE Female, Age 45-49
 AGE Female, Age 50-54
 AGE Female, Age 55-59
 AGE Female, Age 60-64
 AGE Female, Age 65-69
 AGE Female, Age 70-74
 AGE Female, Age 75-79
 AGE Female, Age 80-84
 AGE Female, Age 85+

POVCAT Poverty Decile 2
 POVCAT Poverty Decile 3
 POVCAT Poverty Decile 4
 POVCAT Poverty Decile 5
 POVCAT Poverty Decile 6
 POVCAT Poverty Decile 7
 POVCAT Poverty Decile 8
 POVCAT Poverty Decile 9
 POVCAT Poverty Decile 10 (Highest percent poverty)¹

¹Deciles are based on the percentage of households under the federal poverty level (FPL).

Source: http://qualityindicators.ahrq.gov/Modules/pqi_resources.aspx

Parameter estimates with and without SES covariates (POVCAT) are included with the Technical Specifications.

Please note Version 6.0 will be released publicly in March 2016.

Available in attached Excel or csv file at S.2b

STRATIFICATION

Not applicable.

TYPE SCORE

Rate/proportion better quality = lower score

ALGORITHM

The observed rate of each PQI is simply the number of individuals living in a county admitted to the hospital for the condition of interest divided by the census population estimate for the area (adult population for adult measures and child population for pediatric measures). The expected rate is a comparative rate that incorporates information about a reference population that is not part of the user's input dataset – what rate would be observed if the expected performance observed in the reference population and estimated with risk adjustment regression models, were applied to the mix of patients with demographic distributions observed in the user's dataset? The expected rate is calculated only for risk-adjusted indicators.

The expected rate is estimated for each county using logistic regression.

The risk-adjusted rate is a comparative rate that also incorporates information about a reference population that is not part of the input dataset – what rate would be observed if the performance observed in the user's dataset were applied to a mix of patients with demographics distributed like the reference population? The risk adjusted rate is calculated using the indirect method as observed rate divided by expected rate multiplied by the reference population rate. The smoothed rate is the weighted average of the risk-adjusted rate from the user's input dataset and the rate observed in the reference population; the smoothed rate is calculated with a shrinkage estimator to result in a rate near that from the user's dataset if the provider's rate is estimated in a stable fashion with minimal noise, or to result in a rate near that of the reference population if the variance of the estimated rate from the input dataset is large compared with the hospital-to-hospital variance estimated from the reference population. Thus, the smoothed rate is a weighted average of the risk-adjusted rate and the reference population rate, where the weight is the signal-to-noise ratio. In practice, the smoothed rate brings rates toward the mean, and tends to do this more so for outliers (such as rural counties).

For additional information, please see supporting information in the Quality Indicator Empirical Methods attached in the supplemental files. No diagram provided

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5.1 Identified measures: Not applicable.

5a.1 Are specs completely harmonized? Not applicable.

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

0431 Influenza Vaccination Coverage Among Healthcare Personnel

STEWARD

Centers for Disease Control and Prevention

DESCRIPTION

Percentage of healthcare personnel (HCP) who receive the influenza vaccination.

TYPE

Process

DATA SOURCE

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Management Data, Paper Medical Records, Patient Reported Data/Survey Data sources for required data elements include management/personnel data, medical or occupational health records, vaccination record documents, HCP self-reporting in writing (paper or electronic) that vaccination was received elsewhere, HCP providing documentation of receipt of vaccine elsewhere, verbal or written declination by HCP, and verbal or written documentation of medical contraindications. Available at measure-specific web page URL identified in S.1 Attachment HCP Flu Data Dictionary-635049906022226964.docx

LEVEL

Facility

SETTING

Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

NUMERATOR STATEMENT

HCP in the denominator population who during the time from October 1 (or when the vaccine became available) through March 31 of the following year:

- (a) received an influenza vaccination administered at the healthcare facility, or reported in writing (paper or electronic) or provided documentation that influenza vaccination was received elsewhere; or
- (b) were determined to have a medical contraindication/condition of severe allergic reaction to eggs or to other component(s) of the vaccine, or history of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination; or
- (c) declined influenza vaccination; or
- (d) persons with unknown vaccination status or who do not otherwise meet any of the definitions of the above-mentioned numerator categories.

Numerators are to be calculated separately for each of the above groups.

NUMERATOR DETAILS

1. Persons who declined vaccination because of conditions other than those specified in the 2nd numerator category above should be categorized as declined vaccination.
2. Persons who declined vaccination and did not provide any other information should be categorized as declined vaccination.
3. Persons who did not receive vaccination because of religious or philosophical exemptions should be categorized as declined vaccination.
4. Persons who deferred vaccination all season should be categorized as declined vaccination.
5. The numerator categories are mutually exclusive. The sum of the four numerator categories should be equal to the denominator.

DENOMINATOR STATEMENT

Number of HCP who are working in the healthcare facility for at least 1 working day between October 1 and March 31 of the following year, regardless of clinical responsibility or patient contact.

Denominators are to be calculated separately for:

- (a) Employees: all persons who receive a direct paycheck from the reporting facility (i.e., on the facility's payroll).
- (b) Licensed independent practitioners: include physicians (MD, DO), advanced practice nurses, and physician assistants only who are affiliated with the reporting facility who do not receive a direct paycheck from the reporting facility.
- (c) Adult students/trainees and volunteers: include all students/trainees and volunteers aged 18 or over who do not receive a direct paycheck from the reporting facility.

DENOMINATOR DETAILS

1. Include all HCP in each of the denominator categories who have worked at the facility between October 1 and March 31 for at least 1 working day. This includes persons who joined after October 1 or who left before March 31, or who were on extended leave during part of the reporting period. Working for any number of hours in a day should be counted as a working day.
2. Include both full-time and part-time personnel. If a person works in two or more facilities, each facility should include the person in their denominator.
3. Count persons as individuals rather than full-time equivalents.
4. Licensed practitioners who receive a direct paycheck from the reporting facility, or who are owners of the reporting facility, should be counted as employees.
5. The denominator categories are mutually exclusive. The numerator data are to be reported separately for each of the denominator categories.

EXCLUSIONS

None.

EXCLUSION DETAILS

Not applicable.

RISK ADJUSTMENT

No risk adjustment or risk stratification

Not applicable.

Provided in response box S.15a

STRATIFICATION

The measure should be calculated separately for each denominator group of healthcare personnel: employees; licensed independent practitioners; and adult students/trainees and volunteers. Definitions for these groups are as follows:

(a) Employees: all persons who receive a direct paycheck from the reporting facility (i.e., on the facility's payroll).

(b) Licensed independent practitioners: physicians (MD, DO), advanced practice nurses, and physician assistants who are affiliated with the reporting facility, but are not directly employed by it (i.e., they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact. Post-residency fellows are also included in this category if they are not on the facility's payroll.

(c) Adult students/trainees and volunteers: medical, nursing, or other health professional students, interns, medical residents, or volunteers aged 18 or older who are affiliated with the healthcare facility, but are not directly employed by it (i.e., they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Among each of the denominator groups, the measure may be calculated by dividing the number of HCP in the first numerator category (i.e., received an influenza vaccination) by the number of HCP in that denominator group, and multiplying by 100 to produce a vaccination rate expressed as a percentage of all HCP in the denominator group. Rates of medical contraindications, declinations, and unknown vaccination status can be calculated similarly using the second, third, and fourth numerator categories, respectively.

As noted above, numerator categories should not be summed; each numerator status should be calculated and reported separately. Available at measure-specific web page URL identified in S.1

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5.1 Identified measures: Not applicable.

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: An additional category was added to the numerator statement to explicitly capture "unknown" vaccination status. See Section 4d.1 for rationale.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

STEWARD

Centers for Medicare & Medicaid Services

DESCRIPTION

The measure reports the percentage of short-stay residents or patients who are assessed and appropriately given the seasonal influenza vaccine during the most recently-completed influenza season. The influenza vaccination season (IVS) is defined as beginning on October 1, or when the vaccine first becomes available*, and ends on March 31 of the following year. This measure is based on the NQF's National Voluntary Standards for Influenza and Pneumococcal Immunizations.

The measure is the aggregate of three separately calculated submeasures to reflect the process by which a resident or patient is assessed and appropriately given the influenza vaccination during the current or most recent influenza season.

The three submeasures are as follows:

- residents or patients who received the influenza vaccine during the most recently completed influenza season, either in the facility/hospital or outside the facility/hospital (NQF #0680a);
- residents or patients who were offered and declined the seasonal influenza vaccine (NQF #0680b);
- residents or patients who were ineligible to receive the seasonal influenza vaccine due to contraindication(s) (e.g., anaphylactic hypersensitivity to eggs or other components of the vaccine, see <http://www.cdc.gov/flu/professionals/vaccination/vax-summary.htm>) (NQF #0680c).

*Note: While the IVS officially begins when the vaccine becomes available, which may be before October 1, the denominator time window for the quality measure and references to the IVS for the denominator specification is from October 1 to March 31 of the following year. The numerator time window and references to the IVS in the numerator specifications may include patients and residents who are assessed and offered the vaccine before October 1. This is based on how the influenza items were coded by the facility.

The denominator consists of patients or short-stay residents 180 days of age or older on the target date of assessment who were in the facility/hospital for at least one day during the most recently-completed influenza vaccination season (IVS). The measure is based on data from the Minimum Data Set (MDS) assessments of nursing home residents, Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) assessments for Inpatient Rehabilitation Facility (IRF) patients, and the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set Version assessments of LTCH patients.

Data are collected in each of these three settings using standardized items across the three assessment instruments. For the nursing homes, the measure is limited to short-stay residents, identified as residents who have had 100 or fewer days of nursing home care. For the LTCHs, this measure will include all patients, irrespective of a patient's length of stay. For IRFs, this measure includes all Medicare Part A and Part C patients, irrespective of a patient's length of stay.

TYPE

Process

DATA SOURCE

Electronic Clinical Data Nursing Home Minimum Data Set 3.0, Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), LTCH Continuity Assessment Record & Evaluation (Care) Data Set

Available at measure-specific web page URL identified in S.1 No data dictionary

LEVEL

Facility

SETTING

Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

NUMERATOR STATEMENT

The numerator for the overall measure (NQF #0680) is the number of residents or patients in the denominator sample who, during the numerator time window, meet any one of the following criteria: (1) those who received the seasonal influenza vaccine during the most recently-completed influenza season, either in the facility/hospital or outside the facility/hospital (NQF #0681a); (2) those who were offered and declined the seasonal influenza vaccine (NQF #0681b); or (3) those who were ineligible due to contraindication(s) (NQF #0681c). The numerator time window coincides with the most recently-completed seasonal IVS which begins on October 1 and ends on March 31 of the following year.

Each of the three submeasures numerators described above will be computed and reported separately, alongside the overall numerator calculated as the aggregate of the three submeasure numerators.

NUMERATOR DETAILS

The numerator for the overall measure (NQF #0680) includes all patients or short-stay residents in the denominator sample who, during the numerator time window, meet one of three criteria: (1) received the seasonal influenza vaccine during the most recent influenza season, either inside or outside the facility/hospital, (2) were offered and declined the vaccine, or (3) were ineligible due to medical contraindications.

For each setting (i.e., nursing homes, inpatient rehabilitation facilities, and long-term care hospitals), the numerator components are also computed and reported separately as a submeasure.

Specifications for the three provider type assessment tools are listed below:

MDS: Residents are counted if they are short-stay residents, defined as residents whose length of stay is less than or equal to 100 days. Short-stay residents are included in the numerator for the overall measure (NQF #0680) if they meet any of the following criteria during the numerator time window: (1) received the influenza vaccine during the most recent influenza vaccine season, either in the facility (O0250A=1) or outside the facility (O0250C=2) (also computed and reported separately as a submeasure); or (2) offered and declined the influenza vaccine (O0250C=4) (also computed and reported separately as a submeasure); or (3) ineligible due to

medical contraindication(s) (O0250C=3) (also computed and reportedly separately as a submeasure). Included in the numerator are short-stay residents who meet the criteria on the selected MDS assessment. The record selected will be the record with the latest target date that meets all of the following conditions: (1) it has a qualifying reason for assessment (OBRA (A0310A=01,02,03,04,05,06), PPS (A0310B=01,02,03,04,05,06) or discharge assessment (A0310F=10, 11), (2) the target date is on or after October 1st of the most recently completed influenza season, and (3) the entry date is on or before March 31st of the most recently completed influenza season.

IRF-PAI: Patients are included in the numerator for the overall measure (NQF #0680) for stays that meet any of the following criteria during the numerator time window: (1) received the influenza vaccine during the most recently-completed influenza season, either in the facility (O0250A = 1) or outside the facility (O0250C = 2) ; or (2) offered and declined the influenza vaccine (O0250C = 4; or (3) ineligible due to medical contraindication(s) (O0250C = 3). All three of these also computed and reportedly separately as submeasures. Included in the numerator are patients who meet the criteria based on data reported on the IRF-PAI assessments during the denominator time window. Note: IRF-PAI assessments are submitted to CMS for Medicare Part A and Part C patients.

LTCH CARE Data Set (LCDS): Patients are included in the numerator for the overall measure (NQF #0680) for patient stays that meet any of the following criteria during the numerator time window: (1) received the influenza vaccine during the most recent influenza season, either in the facility (O250A=1) or outside the facility (O0250C=2) ; or (2) offered and declined the influenza vaccine (O0250C=4); or (3) ineligible due to medical contraindication(s) (O0250C=3).All three of these also computed and reportedly separately as submeasures. Included in the numerator are patients who meet the criteria on the LTCH CARE Data Set admission assessment (A0250=01), discharge or expired patient assessment (A0250=10, 11, 12) during the denominator time window. Note: LCDS expired assessments (A0250=12) completed before April 1, 2016 are not included in the numerator because prior to this date the influenza items were not included on expired assessments.

DENOMINATOR STATEMENT

The denominator consists of patients or short-stay residents 180 days of age and older on the target date of the assessment who were in the facility/hospital for at least one day during the denominator time window. The denominator time window is defined as the most recently-completed IVS, from October 1 to March 31 of the following year. For IRF and LTCH, the QM is based on completed patient stays (have discharge assessments). An IRF or LTCH patient with multiple stays during the denominator time window (IVS) will be included more than once in the QM. If a nursing home resident has more than one episode during the denominator time window only the more recent episode is included in this QM.

DENOMINATOR DETAILS

The denominator time window is defined as the most recently-completed IVS, from October 1 to March 31 of the following year. Measure specifications for the three assessment tools are listed below. For IRF and LTCH, the QM is based on stays with admission and discharge assessments. An IRF or LTCH patient with multiple stays during the denominator time window (IVS) will be included more than once in the QM. If a nursing home resident has more than one episode during the denominator time window only the more recent episode is included in this QM.

MDS (in use in Nursing Homes/Skilled Nursing Facilities): Residents are counted if they are short-stay residents, defined as residents whose length of stay is less than or equal to 100 days. The sample includes residents, aged 180 days or older, meeting the following conditions: the resident has an OBRA assessment (A0310A=01,02,03,04,05,06) or PPS assessment (A0310B=01,02,03,04,05,06) or discharge assessment (A0310F=10, 11) with an assessment reference date on or after the start of the denominator time window and an entry date (A1600) on or before the end of the denominator time window.

IRF-PAI (in use in Inpatient Rehabilitation Facilities): Patient stays are included in the sample if patients are 180 days or older and have a stay that includes 1 or more days in the IRF during the denominator time window (the IVS). Patient stays must meet any of the following conditions: (1) the patient has an admission assessment with an entry date (item 12) during the denominator time window; (2) the patient has a discharge assessment with a discharge date (Item 40) during the denominator time window; or (3) the patient has an admission with an entry date (item 12) before the denominator time window and a discharge date (item 40) after the denominator time window.

LTCH CARE Data Set (in use in Long-Term Care Hospitals): Patient stays are included in the sample if patients are 180 days of age or older at discharge and have a stay that includes 1 or more days in the LTCH during the denominator time window. Stays must meet either of the following conditions: (1) a stay with an admission date (A0220) or a planned or unplanned (A0250 = 10, 11) discharge date (A0270) or an expired patient assessment (A0250 = 12) within the denominator time window; or (2) a stay with the admission date (A0220) before the denominator time window and a planned or unplanned discharge (A0250 = 10, 11) with discharge or date (A0270) or a patient expired assessment (A0250 = 12) with date of death (A0270) after the denominator time window.

EXCLUSIONS

Residents or patients whose age is 179 days or less of age on target date of the selected influenza vaccination assessment are excluded. LTCH patients whose expired assessments are completed before April 1, 2016 are excluded. After April 1, 2016 expired patients are no longer excluded from the QM, because the influenza items were added to the LCDS expired assessments. Nursing homes with denominator counts of less than 20 residents and IRFs and LTCHs with less than 20 stays in the sample are excluded from public reporting due to small sample size.

EXCLUSION DETAILS

Residents or patients with age 179 days or less are excluded, with age calculation based on the resident and patient birthdate and the target date of the selected influenza vaccination assessment.

RISK ADJUSTMENT

No risk adjustment or risk stratification.

This section is not applicable.

Provided in response box S.15a

STRATIFICATION

This section is not applicable.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

For each setting the calculation algorithm for the overall measure and submeasures a-c are:

Step 1: Identify the total number of residents or patients meeting the denominator criteria.

Step 2: For the first submeasure (NQF #0680a: Percent of Residents or Patients Who Received the Seasonal Influenza Vaccine (short stay)):

Step 2a: Identify the total number of patients or short-stay residents who received the seasonal influenza vaccine during the current or most recently completed influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]).

Step 2b: Divide the results of Step 2a by the result of Step 1.

Step 3: For the second submeasure (NQF #0680b: Percent of Residents or Patients Who Offered and Declined the Seasonal Influenza Vaccine (short stay)):

Step 3a: Identify the total number of patients or short-stay residents who were offered and declined the seasonal influenza vaccine (O0250C = [4]).

Step 3b: Divide the results of Step 3a by the result of Step 1.

Step 4: For the third submeasure (NQF #0680c: Percent of Residents or Patients Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine (short stay)):

Step 4a: Identify the total number of patients or short-stay residents who were ineligible due to medical contraindication(s) (O0250C = [3]).

Step 4b: Divide the results of Step 4a by the result of Step 1.

Step 5: For the overall measure (NQF #0680: Percent of Residents or Patients Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)):

Step 5a: Aggregate Step 2a, 3a, and 4a [Sum the total number of short-stay residents or patients who met any one of the following criteria: who received the seasonal influenza vaccine during the current or most recently completed influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]); OR who were offered and declined the seasonal influenza vaccine (O0250C = [4]); OR who were ineligible due to medical contraindication(s) (O0250C = [3]).]

Step 5b: Divide the results of Step 5a by the result of Step 1. Available at measure-specific web page URL identified in S.1

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5.1 Identified measures: 0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

1659 : Influenza Immunization

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable.

5b.1 If competing, why superior or rationale for additive value: The current measure for Nursing Homes is expanded to both additional post-acute care settings (LTCHs and IRFs), as well as to additional data sources (MDS 3.0 remained the data source of nursing homes, IRF-PAI is the data source for IRFs, and the LTCH CARE Data Set is the data source for LTCHs).The proposed

measure is harmonized to the NQF Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations.

A possible competing measure is the National Committee for Quality Assurance (NCQA) measure titled: Flu vaccinations for adults ages 65 and older: percentage of Medicare members 65 years of age and older who received an influenza vaccination between July 1 of the measurement year and the date when Medicare CAHPS survey was completed.

This NCQA measure is based on the CAHPS Health Plan Survey and targets a different and non-institutionalized population, so while this is a related measure, it does not compete with NQF #0680, which provides distinctive value.

Another possible competing measure for IRFs and LTCHs is NQF #1659 titled: Influenza Immunization for Hospital/Acute Care Facility AND Institute for Clinical Systems (ICS). The measure suggests immunizations of adult patients 18 years and older to be up to date with all immunization vaccines with follow up time periods.

NQF #1659 targets a different population in multiple settings and does not include those assessed but not given the vaccine. ICS is not NQF endorsed and has a different target population with a broader numerator (multiple other vaccines). NQF #0680 targets a different population in multiple settings, so while it is a related measure, it does not compete with NQF# 0680.

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

STEWARDS

Centers for Medicare & Medicaid Services

DESCRIPTION

This measure reports the percentage of long-stay residents, 180 days of age and older, who were in a nursing facility for at least one day during the most recently completed influenza vaccination season (IVS), and who were assessed and appropriately given the seasonal influenza vaccine. The IVS is defined as beginning on October 1 and ends on March 31 of the following year. The measure is the aggregate of three separately calculated submeasures to reflect the process by which a resident is assessed and appropriately given the influenza vaccination during the current or most recent influenza season.

The three submeasures are as follows:

- resident received the influenza vaccine during the current or most recent influenza season, either in the facility or outside the facility (NQF #0681a);
- resident was offered and declined the seasonal influenza vaccine (NQF #0681b); and
- resident was ineligible to receive the seasonal influenza vaccine due to contraindication(s) (e.g., anaphylactic hypersensitivity to eggs or other components of the vaccine, see <http://www.cdc.gov/flu/professionals/vaccination/vax-summary.htm>) (NQF #0681c).

The denominator consists of long-stay residents 180 days of age or older on the target date of assessment who were in the facility for at least one day during the most recently-completed influenza vaccination season (IVS). This measure is based on data from the Minimum Data Set (MDS 3.0) OBRA, PPS, and/or discharge assessments during the selected influenza season. Long-

stay residents are identified as those who have had 101 or more cumulative days of nursing facility care.

A separate measure (NQF #0680, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)) is to be used for residents who have had 100 or fewer cumulative days of nursing facility care.

TYPE

Process

DATA SOURCE

Electronic Clinical Data Nursing Home Minimum Data Set 3.0

Available at measure-specific web page URL identified in S.1 No data dictionary

LEVEL

Facility

SETTING

Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

NUMERATOR STATEMENT

The numerator is the number of long-stay residents with a target assessment (OBRA admission, quarterly, annual or significant change/correction assessments; PPS 5-,14-, 30-, 60-, 90-day, or readmission/return assessments; or discharge assessment with or without return anticipated) who were in the denominator sample, AND who meet any of the following criteria for the selected influenza season: (1) they received the influenza vaccine during the most recent influenza season, either in the facility or outside the facility (NQF #0681a), (2) they were offered and declined the influenza vaccine (NQF #0681b), or (3) they were ineligible due to medical contraindication(s) (NQF #0681c) . The influenza season is defined as July 1 of the current year to June 30 of the following year. The IVS begins on October 1 and ends on March 31 of the following year.

Each of the three submeasure numerators described above will be computed and reported separately, alongside the overall numerator calculated as the aggregate of the three submeasure numerators.

NUMERATOR DETAILS

Residents are counted if they are long-stay residents, defined as residents who have had 101 or more cumulative days of nursing facility care, are 180 days of age and older and who were in a nursing facility for at least one day during the most recently completed IVS. Residents who return to the nursing home following a hospital discharge will not have their stay reset to zero. The numerator is the number of long-stay residents in the denominator sample with a selected target assessment (OBRA admission, quarterly, annual or significant change/correction assessments; PPS 5-, 14-, 30-, 60-, 90-day, or readmission/return assessments; or discharge assessment with or without return anticipated) during the most recently selected influenza season who meet any of the following criteria:

(1) Resident received the influenza vaccine during the most recent influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]) (NQF #0681a, computed separately); or

(2) Resident was offered and declined the influenza vaccine (O0250C = [4]) (NQF #0681b, computed separately); or

(3) Resident was ineligible due to contraindication(s) (O0250C = [3]) (NQF #0681c, computed separately) (e.g., anaphylactic hypersensitivity to eggs or other components of the vaccine).

DENOMINATOR STATEMENT

The denominator is the total number of long-stay residents 180 days of age or older on the target date of the assessment who were in the nursing facility who were in a nursing facility for at least one day during the most recently completed IVS that have an OBRA, PPS, or discharge assessment and who did not meet the exclusion criteria.

DENOMINATOR DETAILS

Residents are counted if they are long-stay residents, defined as residents who have had 101 or more cumulative days of nursing facility care. Residents who return to the nursing home following a hospital discharge will not have their length of stay reset to zero. The target population includes all long-stay residents with a target assessment (assessments may be OBRA admission, quarterly, annual or significant change/correction assessments (A0310A = 01, 02, 03, 04, 05, 06) or PPS 5-, 14-, 30-, 60-, 90-day, or readmission/return assessments (A0310B = 01, 02, 03, 04, 05, 06) or discharge assessment with or without return anticipated (A0310F = 10, 11) who were in a nursing facility for at least one day during the most recently completed IVS, except for those who meet the exclusion criteria (specified in S.10 and S.11).

EXCLUSIONS

Residents whose age is 179 days or less on target date of selected influenza vaccination assessment are excluded.

If the facility sample includes fewer than 30 residents after all other resident-level exclusions are applied, then the facility is excluded from public reporting.

EXCLUSION DETAILS

Residents whose age is 179 days or less are excluded, with age calculation based on the resident birthdate and the target date of the selected influenza vaccination assessment.

RISK ADJUSTMENT

No risk adjustment or risk stratification.

This is not applicable.

Provided in response box S.15a

STRATIFICATION

This is not applicable.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

The calculation algorithm for the overall measure and submeasures a-c are:

Step 1: Identify the total number of residents meeting the denominator criteria.

For the first submeasure (NQF #0681a: Percent of Residents Who Received the Seasonal Influenza Vaccine (long stay)):

Step 2a: Identify the total number of long-stay residents who received the seasonal influenza vaccine during the current or most recently completed influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]).

Step 3a: Divide the results of Step 2a by the result of Step 1.

For the second submeasure (NQF #0681b: Percent of Residents Who Offered and Declined the Seasonal Influenza Vaccine (long stay)):

Step 2b: Identify the total number of long-stay residents who were offered and declined the seasonal influenza vaccine (O0250C = [4]).

Step 3b: Divide the results of Step 2b by the result of Step 1.

For the third submeasure (NQF #0681c: Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine (long stay)):

Step 2c: Identify the total number of long-stay residents who were ineligible due to medical contraindication(s) (O0250C = [3]).

Step 3c: Divide the results of Step 2c by the result of Step 1.

For the overall measure (NQF #0681: Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)):

Step 2d: Aggregate Step 2a, 2b, and 2c [Sum the total number of long-stay residents who met any of the following criteria: who received the seasonal influenza vaccine during the current or most recently completed influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]); OR who were offered and declined the seasonal influenza vaccine (O0250C = [4]); OR who were ineligible due to medical contraindication(s) (O0250C = [3]).]

Step 3d: Divide the results of Step 2d by the result of Step 1. Available at measure-specific web page URL identified in S.1

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5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

1659 : Influenza Immunization

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable.

5b.1 If competing, why superior or rationale for additive value: NQF #0680 Percent of Residents or Patients Assessed and Appropriately Given the Seasonal Influenza Vaccine (SS) applies to short-stay nursing home residents as well as additional post-acute care settings (LTCHs and IRFs), and is based on different data sources for each setting (MDS 3.0 for nursing homes, IRF-PAI is the data source for IRFs, and the LTCH CARE Data Set is the data source for LTCHs). Both NQF #0680 and the current measure #0681 for long stay nursing home residents were developed together and harmonized to the NQF Voluntary Consensus Standards for Influenza Immunizations and each other as much as possible.

A possible competing measure is NQF #1659: Influenza Immunization for Hospital/Acute Care Facility AND Institute for Clinical Systems (ICS) suggest immunizations of adult patients 18 years and older, to be up to date with all immunization vaccines with follow up time periods. NQF #1659 targets a different population in a different setting and does not include those assessed

but not given the vaccine. ICS is not NQF endorsed and has a different target population with a broader numerator (multiple other vaccines). NQF #0680 targets a different population in multiple settings.

Another possible competing measure is the National Committee for Quality Assurance (NCQA) measure titled: Flu vaccinations for adults ages 65 and older: percentage of Medicare members 65 years of age and older who received an influenza vaccination between July 1 of the measurement year and the date when Medicare CAHPS survey was completed.

This NCQA measure is based on the CAHPS Health Plan Survey and targets a different and non-institutionalized population, so NQF #0681 offers distinctive value.

1659 Influenza Immunization

STEWARD

Centers for Medicare and Medicaid Services

DESCRIPTION

Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.

TYPE

Process

DATA SOURCE

Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Medical Records
An electronic data collection tool is made available from vendors or facilities can download the free CMS Abstraction & Reporting Tool (CART). Paper tools for manual abstraction, which are posted on www.QualityNet.org, are also available for the CART tool. These tools are posted on www.QualityNet.org.

Available at measure-specific web page URL identified in S.1 Attachment
Appendix_A.Table_12.10_Organ_Transplant_ICD-10__ICD-9_codes.xls

LEVEL

Facility

SETTING

Hospital/Acute Care Facility

NUMERATOR STATEMENT

Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated.

NUMERATOR DETAILS

The following are included in the numerator:

- Patients who received the influenza vaccine during this inpatient hospitalization
- Patients who received the influenza vaccine during the current year's flu season but prior to the current hospitalization

- Patients who were offered and declined the influenza vaccine
- Patients who have an allergy/sensitivity to the influenza vaccine, anaphylactic latex allergy or anaphylactic allergy to eggs, or for whom the vaccine is not likely to be effective because of bone marrow transplant within the past 6 months, or history of Guillian-Barre Syndrome within 6 weeks after a previous influenza vaccination

Data Elements required for the numerator:

- ICD-10-CM Other Diagnosis Codes
- ICD-10-PCS Other Procedure Codes
- ICD-10-CM Principal Diagnosis Code
- ICD-10-PCS Principal Procedure Code
- Influenza Vaccination Status

DENOMINATOR STATEMENT

Acute care hospitalized inpatients age 6 months and older discharged during the months of October, November, December, January, February or March.

DENOMINATOR DETAILS

Data Elements required for the denominator:

- Admission Date
- Birthdate
- Discharge Date
- Discharge Disposition
- ICD-10-PCS Other Procedure Codes
- ICD-10-PCS Principal Procedure Code

EXCLUSIONS

The following patients are excluded from the denominator:

- Patients less than 6 months of age
- Patients who expire prior to hospital discharge
- Patients with an organ transplant during the current hospitalization (Appendix_A.Table 12.10 Organ Transplant codes.xls)
- Patients for whom vaccination was indicated, but supply had not been received by the hospital due to problems with vaccine production or distribution
- Patients who have a Length of Stay greater than 120 days
- Patients who are transferred or discharged to another acute care hospital
- Patients who leave Against Medical Advice (AMA)

EXCLUSION DETAILS

To determine the length of stay, the admission date and discharge date are entered. If the result of the calculation subtracting the admission date from the discharge date is greater than 120 days the patient is excluded from the measure.

The patient's date of birth is entered. If the calculation result of the admission date minus the birth date is less than 6 months the patient is excluded from the measure.

Patients who had an organ transplant during the current hospitalization are excluded based on having an ICD-10 PCS Principal or Other Procedure Code assigned as having occurred during the current hospitalization. If the patient has at least one code from the list on Appendix_A.Table 12.10 Organ Transplant codes.xls assigned for the current hospitalization they are excluded.

Discharge Disposition is a manually abstracted data element. If documentation in the patient's medical record is consistent with the criteria specified in the Discharge Disposition data element for discharge to an acute care facility, patient expired prior to hospital discharge, or the patient left against medical advice the patient is excluded from the measure.

The Influenza Vaccination Status is a manually abstracted data element for the measure. Allowable Value 6 may be selected if there is documentation in the medical record reflecting the hospital has ordered the influenza vaccine but has not yet received it based on problems with vaccine production or distribution. If this value is selected the measure algorithm will exclude the patient from the measure.

RISK ADJUSTMENT

No risk adjustment or risk stratification.

N/A

STRATIFICATION

Measure is not stratified.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Numerator: Inpatient discharges who were screened for Influenza vaccine status and were vaccinated prior to discharge if indicated.

Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October, November, December, January, February or March.

Variable Key: Patient Age

1. Start processing. Run cases that are included in the Global Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.
2. Calculate Patient Age. Patient Age, in years, is equal to the Admission Date minus the Birthdate. Use the month and day portion of admission date and birthdate to yield the most accurate age. Only cases with valid Admission Date and Birthdate will pass the critical feedback messages into the measure specific algorithms.
3. Check Patient Age
 - a. If the Patient Age is less than 6 months old, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
 - b. If the Patient Age is greater than or equal to 6 months, continue processing and proceed to ICD-10-PCS Principal or Other Procedure Codes.
4. Check ICD-10-PCS Principal or Other Procedure Codes
 - a. If at least one of ICD-10-PCS Principal or Other Procedure Codes is on Appendix_A.Table 12.10 Organ Transplant codes.xls the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.

- b. If all of ICD-10-PCS Principal or Other Procedure Codes are missing or none of ICD-10-PCS Principal or Other Procedure Codes is on Appendix_A.Table 12.10 Organ Transplant codes.xls, continue processing and check Discharge Disposition.
- 5. Check Discharge Disposition
 - a. If Discharge Disposition equals 4, 6, or 7 the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
 - b. If Discharge Disposition equals 1, 2, 3, 5, or 8 continue processing and proceed to Discharge Date.
 - c. If Discharge Disposition is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
- 6. Check Discharge Date. Note: 'yyyy' refers to the specific year of discharge.
 - a. If the Discharge Date is 04-01-yyyy through 09-30-yyyy, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
 - b. If the Discharge Date is 10-01-yyyy through 03-31-yyyy, continue processing and proceed to Influenza Vaccination Status.
- 7. Check Influenza Vaccination Status
 - a. If Influenza Vaccination Status is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
 - b. If Influenza Vaccination Status equals 6, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
 - c. If Influenza Vaccination Status equals 1, 2, 3, 4, or 5, continue processing and recheck Influenza Vaccination Status.
- 8. Recheck Influenza Vaccination Status
 - a. If Influenza Vaccination Status equals 5, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.
 - b. If Influenza Vaccination Status equals 1, 2, 3, or 4 the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing. Available at measure-specific web page URL identified in S.1

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- 5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)
- 0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)
- 0226 : Influenza Immunization in the ESRD Population (Facility Level)
- 0038 : Childhood Immunization Status (CIS)
- 0039 : Flu Vaccinations for Adults Ages 18 and Older
- 0041 : Preventive Care and Screening: Influenza Immunization
- 0431 : Influenza Vaccination Coverage Among Healthcare Personnel
- 0522 : Influenza Immunization Received for Current Flu Season (Home Health)
- 5a.1 Are specs completely harmonized? No
- 5a.2 If not completely harmonized, identify difference, rationale, impact: Measures focus on different patient populations based on age, health conditions or location (e.g., home health,

physician office, short term skilled, long term stay, acute care hospital, etc.). There are some differences in Exclusions and Inclusions specific to the population. These differences are in part based upon procedures that may be performed in an acute care hospital that would not be performed in a skilled setting or physician office setting. Additionally IMM-2 excludes cases in which the vaccine has been ordered but it has not yet been received. We've found in the past that there have been some seasons in which the vaccine became available much later than expected and seasons in which there were shortages. We prefer to exclude these cases if there is documentation in the chart to support either of these scenarios

5b.1 If competing, why superior or rationale for additive value: Multiple measures are justified because they each focus on a different patient population. A single measure could not capture the variability inherent in these different populations.

IMM-2 is the only measure that focuses on patients in the acute care hospital setting.

2828 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

STEWARD

Centers for Medicare & Medicaid Services

DESCRIPTION

Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter

Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30

Age 18 – 64 years BMI ≥ 18.5 and < 25

TYPE

Process

DATA SOURCE

Electronic Clinical Data : Electronic Health Record N/A

No data collection instrument provided Attachment NQF3039_NQF2828_Code_Table_S2.b.xlsx

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic

NUMERATOR STATEMENT

Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.

NUMERATOR DETAILS

Within the eMeasure specification, value sets contain relevant codes to capture the numerator. (See attached code table for numerator specific coding in S2.b)

Specific Guidance is as follows:

There is no diagnosis associated with this measure. This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding.

BMI Measurement Guidance:

Height and Weight - An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within six months of the current encounter and may be obtained from separate encounters. Self-reported values cannot be used.

The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider.

If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous six months of the current encounter.

The documented follow-up plan must be based on the most recent documented BMI, outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters". (See Definitions for examples of a follow-up plan treatments).

If more than one BMI is reported during the measurement period, the most recent BMI will be used to determine if the performance has been met.

Definitions:

BMI – Body mass index (BMI), is a number calculated using the Quetelet index: weight divided by height squared (W/H²) and is commonly used to classify weight categories. BMI can be calculated using:

Metric Units: $BMI = \text{Weight (kg)} / (\text{Height (m)} \times \text{Height (m)})$

OR

English Units: $BMI = \text{Weight (lb)} / (\text{Height (in)} \times \text{Height (in)}) \times 703$

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up plan may include, but is not limited to: documentation of education, referral (e.g., a registered dietitian, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon), pharmacological interventions, dietary supplements, exercise counseling, or nutrition counseling.

DENOMINATOR STATEMENT

There are two (2) Initial Patient Populations for this measure:

Initial Patient Population 1: All patients 18 through 64 years on the date of the encounter with at least one eligible encounter during the measurement period.

Initial Patient Population 2: All patients 65 years of age and older on the date of the encounter with at least one eligible encounter during the measurement period.

DENOMINATOR DETAILS

Within the eMeasure specification, value sets contain relevant codes to capture the initial patient populations. (See attached code table for S2.b for specific coding.)

Denominator Criteria (Eligible Cases)

Denominator equals initial patient population

There are two (2) Initial Patient Populations for this measure.

Initial Patient Population 1: All patients 18 through 64 years on the date of the encounter with at least one eligible encounter during the measurement period.

Initial Patient Population 2: All patients 65 years of age and older on the date of the encounter with at least one eligible encounter during the measurement period.

EXCLUSIONS

Initial Patient Population 1: Patients who are pregnant or encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate.

Initial Patient Population 2: Encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate.

EXCLUSION DETAILS

Within the e Measure specification, value sets contain relevant codes to capture the exclusions. (See attached code table for S2.b for specific coding)

RISK ADJUSTMENT

No risk adjustment or risk stratification

N/A

URL

STRATIFICATION

No stratification.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Performance Calculation

To calculate provider performance, complete a fraction with the following measure components: Numerator (A), Performance Denominator (PD), and Denominator Exclusions (B).

Numerator (A): Number of patients meeting numerator criteria

Performance Denominator (PD): Number of patients meeting criteria for denominator inclusion

Denominator Exclusions (B): Number of patients with valid exclusions

The method of performance calculation is determined by the following:

1. Identify the patients who meet the eligibility criteria for the denominator (PD), which includes patients who are 18 years and older with appropriate encounters as defined by encounter codes or encounter value set during the reporting period.

2. Identify which of those patients meet the numerator criteria (A)

3. For those patients who do not meet the numerator criteria, determine whether an appropriate exclusion applies (B) and subtract those patients from the denominator with the following calculation: Numerator (A)/[Performance Denominator (PD) - Denominator Exclusions (B)] Available in attached appendix at A.1

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5.1 Identified measures: 0024 : Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

1349 : Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)

2601 : Body Mass Index Screening and Follow-Up for People with Serious Mental Illness

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: NQF0024 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) has a similar, but not identical, focus. First, NQF0024 requires counseling for nutrition and physical activity based on the results of the weight assessment, while our measure allows greater provider discretion when selecting the best type of follow-up. NQF0024 also has a different target population (children and adolescents aged 3-17, rather than adults 18 and older). Both are process measures focused on Ambulatory Care: Clinician Office/Clinic settings, but our measure is also appropriate for other settings of care (for instance, Outpatient Rehabilitation, Behavioral Health/Psychiatric: Outpatient, Home Health, and Other). NQF1349 - Child Overweight or Obesity Status Based on Parental Report of Body Mass Index (BMI) has a similar focus, but differs in target population (it is specific to children and adolescents aged 10-17, rather than adults 18 and older), the calculation of BMI (it is based on parent-reported height and weight of the child rather than actual BMI value), and uses CDC BMI-for-age guidelines in attributing overweight and obesity status (85th – 94th percentile up to 95th-and-above percentile rather than specific parameters to classify obesity from AHA/ACC/TOS and the National Heart, Lung and Blood Institute (NHLBI) clinical guidelines). Last, NQF1349 does not require documentation of a recommendation for follow-up for under- or overweight findings, whereas our measure requires that a follow-up plan be documented for any BMI outside normal range. NQF1349 is an outcome measure, and the care setting is identified as Other. Our measure is a process measure, but it is also appropriate for other settings of care (for instance, NQF0421 is also appropriate for Outpatient Rehabilitation, Behavioral Health/Psychiatric: Outpatient, Home Health, and Other.) NQF2601- Body Mass Index Screening and Follow-up for People with Serious Mental Illness shares a similar measure focus (BMI and Screening and Follow-up) and target population (18 years and older.) However NQF2601 is specific to patients with a serious mental illness whereas NQF0421 is not specific to a certain illness and incorporates the general population. Both are process measures, but our measure is more inclusive than NQF2601. Not only does our measure include all patients, not just those with severe mental illness, but it is also appropriate for other settings of care (for instance, NQF0421 is appropriate for Ambulatory Care: Clinician Office/Clinic, Ambulatory Care: Outpatient Rehabilitation, Behavioral Health/Psychiatric: Outpatient, Home Health, and Other while NQF2601 includes only Ambulatory Care: Clinician Office/Clinic, Behavioral Health/Psychiatric: Outpatient.)

5b.1 If competing, why superior or rationale for additive value: N/A

3039 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

STEWARD

Centers for Medicare & Medicaid Services

DESCRIPTION

Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter

Normal Parameters:

Age 65 years and older BMI ≥ 23 and < 30 kg/m²

Age 18–64 years BMI ≥ 18.5 and < 25 kg/m²

TYPE

Process

DATA SOURCE

Administrative claims, Electronic Clinical Data : Registry N/A

No data collection instrument provided Attachment NQF3039_NQF2828_Code_Table_S2.b-636023587193379611.xlsx

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic

NUMERATOR STATEMENT

Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.

NUMERATOR DETAILS

Instructions include the following: There is no diagnosis associated with this measure. This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding. The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider. If the most recent documented BMI is outside of normal parameters, then a follow-up plan must be documented during the encounter or during the previous six months of the current encounter. The documented follow-up plan must be based on the most recent document BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters" (See Definitions for examples of a follow-up plan treatments). If more than one BMI is reported during the measure period, the most recent BMI will be used to determine if the performance has been met.

Definitions:

BMI – Body mass index (BMI), is a number calculated using the Quetelet index: weight divided by height squared (W/H²) and is commonly used to classify weight categories. BMI can be calculated using:

Metric Units: BMI = Weight (kg) / (Height (m) × Height (m))

OR

English Units: BMI = Weight (lb) / (Height (in) × Height (in)) × 703

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up plan may include but is not limited to: documentation education, a referral (e.g., a registered dietitian, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon), pharmacological interventions, dietary supplements, exercise counseling, or nutrition counseling.

Not Eligible for BMI Calculation or Follow-Up Plan – A patient is not eligible if one or more of the following reasons are documented:

- Patient is receiving palliative care
- Patient is pregnant
- Patient refuses BMI measurement (refuses height and/or weight)
- Any other reason documented in the medical record by the provider why BMI calculation or follow-up plan was not appropriate
- Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status

Quality Data Codes (QDCs) are a subset of non-billable HCPCS II codes that providers submit with Medicare Part B claims to delineate their clinical quality actions. There are 7 QDC options for this measure.

Numerator Quality-Data Coding Options for Reporting Satisfactorily

BMI Documented as Normal, No Follow-Up Plan Required

(One quality-data code [G8417, G8418 or G8420] is required on the claim form to submit this numerator option)

G8420: BMI is documented within normal parameters and no follow-up plan is required

OR

BMI Documented as Above Normal Parameters, AND Follow-Up Documented

G8417: BMI is documented above normal parameters and a follow-up plan is documented

OR

BMI Documented as Below Normal Parameters, AND Follow-Up Documented

G8418: BMI is documented below normal parameters and a follow-up plan is documented

OR

BMI not Documented, Patient not Eligible

(One quality-data code [G8422 or G8938] is required on the claim form to submit this numerator option)

G8422: BMI not documented, documentation the patient is not eligible for BMI calculation

OR

BMI Documented Outside of Normal Limits, Follow-up Plan not Documented, Patient not Eligible
G8938: BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation the patient is not eligible

OR

BMI not Documented, Reason not Given

(One quality-data code [G8419 or G8421] is required on the claim form to submit this numerator option)

G8421: BMI not documented and no reason is given

OR

BMI Documented Outside of Normal Parameters, Follow-Up Plan not Documented, Reason not Given

G8419: BMI documented outside normal parameters, no follow-up plan documented, no reason given

DENOMINATOR STATEMENT

All patients aged 18 years and older

DENOMINATOR DETAILS

Lists of individual codes with descriptors for the measure specification is provided in an Excel file at S.2b

Patients aged >18 years on date of encounter

Denominator Criteria (Eligible Cases): Patient encounter during the reporting period (CPT and HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 96150, 96151, 96152, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447

EXCLUSIONS

Not Eligible for BMI Calculation or Follow-Up Plan – A patient is not eligible if one or more of the following reasons are documented:

Patient is receiving palliative care

Patient is pregnant

Patient refuses BMI measurement (refuses height and/or weight)

Any other reason documented in the medical record by the provider why BMI calculation or follow-up plan was not appropriate

Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status

EXCLUSION DETAILS

To calculate the performance rate, exclude the following QDCs from the denominator

Performance exclusion

BMI not Documented, Patient not Eligible

G8422: BMI not documented, documentation the patient is not eligible for BMI calculation

OR

BMI Documented Outside of Normal Limits, Follow-up Plan not Documented, Patient not Eligible
G8938: BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation the patient is not eligible

RISK ADJUSTMENT

No risk adjustment or risk stratification.

N/A

URL

STRATIFICATION

No stratification.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

PERFORMANCE CALCULATION

To calculate provider performance, complete a fraction with the following measure components: Numerator (A), Performance Denominator (PD), and Denominator Exclusions (B).

Numerator (A): Number of patients meeting numerator criteria

Performance Denominator (PD): Number of patients meeting criteria for denominator inclusion

Denominator Exclusions (B): Number of patients with valid exclusions

The method of performance calculation is determined by the following:

1. Identify the patients who meet the eligibility criteria for the denominator (PD), which includes patients who are 18 years and older with appropriate encounters as defined by encounter codes or encounter value set during the reporting period.
2. Identify which of those patients meet the numerator criteria (A)
3. For those patients who do not meet the numerator criteria, determine whether an appropriate exclusion applies (B) and subtract those patients from the denominator with the following calculation: Numerator (A)/[Performance Denominator (PD) - Denominator Exclusions (B)] Available in attached appendix at A.1

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5.1 Identified measures: 0024 : Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

1349 : Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)

2601 : Body Mass Index Screening and Follow-Up for People with Serious Mental Illness

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: NQF 0024 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) has a similar, but not identical, measure focus. First, NQF0024 requires counseling for nutrition and physical activity based on the results of the weight assessment, while our measure allows for greater provider discretion when selecting the best type of follow-up. NQF0024 also has a different target population (children and adolescents aged 3-17, rather than adults 18 and older). Both are process measures focused on Ambulatory Care: Clinician Office/Clinic settings,

but our measure is also appropriate for other settings of care (for instance, Outpatient Rehabilitation, Behavioral Health/Psychiatric: Outpatient, Home Health, and Other.) NQF1349 - Child Overweight or Obesity Status Based on Parental Report of Body Mass Index (BMI) has a similar measure focus, but differs in target population (is specific to children and adolescents aged 10-17, rather than adults 18 and older), the calculation of BMI (is based on parent-reported height and weight of the child rather than actual BMI value),the measure uses CDC BMI-for-age guidelines in attributing overweight and obesity status (85th–94th percentile up to 95th-and-above percentile rather than specific parameters to classify obesity from AHA/ACC/TOS and the National Heart, Lung and Blood Institute (NHLBI) clinical guidelines). Last, NQF1349 does not require documentation of a recommendation for follow-up for under or overweight findings whereas our measure requires that a follow up plan be documented for any BMI outside normal range. NQF1349 is an outcome measure, and the care setting is identified as other. Our measure is a process measure, but it is also appropriate for other settings of care (for instance, NQF3039 is also appropriate for Outpatient Rehabilitation, Behavioral Health/Psychiatric: Outpatient, Home Health, and Other.) NQF2601 - Body Mass Index Screening and Follow-up for People with Serious Mental Illness shares a similar measure focus (BMI and Screening and Follow-up) and target population (18 years and older.) However, NQF2601 is specific to patients with a serious mental illness, whereas NQF3039 is not specific to a certain illness and incorporates the general population. Both are process measures, but our measure is more inclusive than NQF2601. Not only does our measure include all patients, not just those with severe mental illness, but it is also appropriate in other settings of care (for instance, NQF3039 is appropriate for Ambulatory Care: Clinician Office/Clinic, Ambulatory Care: Outpatient Rehabilitation, Behavioral Health/Psychiatric: Outpatient, Home Health, and Other while NQF2601 includes only Ambulatory Care: Clinician Office/Clinic, Behavioral Health/Psychiatric: Outpatient).

5b.1 If competing, why superior or rationale for additive value: N/A

3059 One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk

STEWARD

PCPI Foundation

DESCRIPTION

Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945–1965 who received one- time screening for hepatitis C virus (HCV) infection

TYPE

Process

DATA SOURCE

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Not applicable
 No data collection instrument provided Attachment
 HCVOnetimeScreenAtRisk_ValueSets_06152016-636028063649880456.xlsx

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic, Home Health, Post Acute/Long Term Care Facility :
Nursing Home/Skilled Nursing Facility, Other Domiciliary

NUMERATOR STATEMENT

Patients who received one-time screening for HCV infection

NUMERATOR DETAILS

For EHR:

Health Quality Measures Format (HQMF) eMeasure developed and is attached to this submission in field S.2a.

We have provided the following definitions and/or guidance for convenience; please see HQMF eMeasure for complete details related to the specification.

NUMERATOR DEFINITION:

Screening for HCV Infection includes current or prior receipt of:

- 1) HCV antibody test
- 2) HCV RNA test
- 3) Recombinant immunoblot assay (RIBA) test (if performed at any time in the past)

NUMERATOR GUIDANCE:

This measure evaluates the proportion of at-risk patients who have received a one-time screening for Hepatitis C Virus (HCV). In order to meet the measure, the reporting provider must have the laboratory test result present in the patient's medical record. On occasion, providers will view HCV screening results that were performed elsewhere and therefore the results are not present in the EHR in a structured format. To allow such tests to be applied to this measure, they should be entered into the EHR as a laboratory test in a manner consistent with the EHR in use. If the specific LOINC code of the test is not known, the entry should use the more generic LOINC Panel code which is included in the HCV test value sets as outlined below:

If the provider does not know the exact HCV RNA test performed elsewhere, report the generic LOINC HCV RNA Panel code 75888-8, found in the value set titled, "HCV RNA Test".

If the provider does not know the exact HCV Antibody test performed elsewhere, report the generic LOINC HCV Ab Panel code, 75886-2, found in the value set titled, "HCV Antibody Test".

If the provider does not know the exact HCV RIBA test performed elsewhere, report the generic LOINC HCV RIBA Panel code, 75887-0, found in the value set, "HCV RIBA Test".

The following screening tests are included as allowable screening tests for HCV: HCV antibody test, HCV RNA test or RIBA test. The RIBA test qualifies as "one-time screening" if it was performed at some time in the past. Because RIBA is not a screening method currently used in clinical practice, it is not included as an option in the numerator logic for a screening that occurred during the measurement period.

DENOMINATOR STATEMENT

All patients aged 18 years and older who were seen twice for any visit or who had at least one preventive visit within the 12 month reporting period with one or more of the following: a

history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945–1965

DENOMINATOR DETAILS

For EHR:

HQMF eMeasure developed and is attached to this submission in field S.2a.

DENOMINATOR GUIDANCE:

The start datetime stamp associated with the data element "Diagnosis: History of Blood Transfusion" should be the datetime of the transfusion event, and not a datetime stamp associated with the documentation action in order to satisfy the logic clause.

EXCLUSIONS

Denominator Exclusions:

Patients with a diagnosis of chronic hepatitis C

Denominator Exceptions:

Documentation of medical reason(s) for not receiving one-time screening for HCV infection (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons)

Documentation of patient reason(s) for not receiving one-time screening for HCV infection (eg, patient declined, other patient reasons)

EXCLUSION DETAILS

The PCPI distinguishes between measure exceptions and measure exclusions. Exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (ie, the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision. For measure, "One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk," exclusions include diagnosis of chronic hepatitis C. Exclusions, including applicable value sets, are included in the measure specifications.

Measure Exceptions

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure, "One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk," exceptions may include medical reason(s) for not receiving one-time screening for HCV infection (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical

reasons, and patient reason(s) (eg, patient declined, other patient reasons) for the patient not receiving the screening. Where examples of exceptions are included in the measure language, value sets for these examples are developed and included in the eMeasure. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Additional details by data source are as follows:

For EHR:

HQMF eMeasure developed and is attached to this submission in field S.2a.

RISK ADJUSTMENT

No risk adjustment or risk stratification.

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator. (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.
3. Find the patients who qualify for denominator exclusions and subtract from the denominator.
4. From the patients within the denominator (after denominator exclusions have been subtracted from the denominator), find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.
5. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: documentation of medical reason(s) for not receiving one-time screening for HCV infection (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons) and patient reason(s) (eg, patient declined, other patient reasons) for the patient not receiving the screening]. If the patient meets any exception criteria, they should be removed from the

denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage of patients with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. No diagram provided

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5.1 Identified measures: 0393 : Hepatitis C: Confirmation of Hepatitis C Viremia

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: The quality action performed in measure 0393 is confirming the hepatitis C antibody is present following initial testing and does not include the initial testing before diagnosis as a part of the quality action performed in the measure.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

3060 Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users

STEWARD

PCPI Foundation

DESCRIPTION

Percentage of patients, regardless of age, who are active injection drug users who received screening for HCV infection within the 12 month reporting period

TYPE

Process

DATA SOURCE

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Not applicable
No data collection instrument provided Attachment
HCVAnnualScreenDrugUser_ValueSets_06152016-636028069682891411.xlsx

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic, Home Health, Post Acute/Long Term Care Facility :
Nursing Home/Skilled Nursing Facility, Other Domiciliary

NUMERATOR STATEMENT

Patients who received screening for HCV infection within the 12 month reporting period

NUMERATOR DETAILS

For EHR:

Health Quality Measures Format (HQMF) eMeasure developed and is attached to this submission in field S.2a.

We have provided the following definitions and/or guidance for convenience; please see HQMF eMeasure for complete details related to the specification.

NUMERATOR DEFINITION:

Screening for HCV infection - includes HCV antibody test or HCV RNA test

NUMERATOR GUIDANCE:

This measure evaluates the proportion of patients who are active injection drug users, who receive screening for Hepatitis C Virus (HCV). In order to meet the measure, the reporting provider must have the laboratory test result present in the patient's medical record. On occasion, providers will view HCV screening results that were performed elsewhere and therefore the results are not present in the EHR in a structured format. To allow such tests to be applied to this measure, they should be entered into the EHR as a laboratory test in a manner consistent with the EHR in use. If the specific LOINC code of the test is not known, the entry should use the more generic LOINC code which is present in the HCV test value sets as outlined below:

If the provider does not know the exact HCV RNA test performed elsewhere, report the generic LOINC HCV RNA Panel Code, 75888-8, found in the value set titled, "HCV RNA Test".

If the provider does not know the exact HCV Antibody test performed elsewhere, report the generic LOINC HCV Ab Panel code, 75886-2, found in the value set title, "HCV Antibody Test".

DENOMINATOR STATEMENT

All patients, regardless of age, who are seen twice for any visit or who had at least one preventive care visit within the 12 month reporting period who are active injection drug users

DENOMINATOR DETAILS

For EHR:

HQMF eMeasure developed and is attached to this submission in field S.2a.

DENOMINATOR DEFINITION:

Active injection drug users are those who have injected any drug(s) within the past 12 months

EXCLUSIONS

Denominator Exclusions:

Patients with a diagnosis of chronic hepatitis C

Denominator Exceptions:

Documentation of medical reason(s) for not receiving annual screening for HCV infection (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons)

Documentation of patient reason(s) for not receiving annual screening for HCV infection (eg, patient declined, other patient reasons)

EXCLUSION DETAILS

The PCPI distinguishes between measure exceptions and measure exclusions. Exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who

are otherwise included in the initial patient or eligible population of a measure (ie, the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision. For measure, "Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users," exclusions include patients with a diagnosis of chronic hepatitis C. Exclusions, including applicable value sets, are included in the measure specifications.

Measure Exceptions

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of exception reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure, "Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users," medical exceptions may include decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons and patient reason(s) (eg, patient declined, other patient reasons) for the patient not receiving the receiving annual screening for HCV infection. Where examples of exceptions are included in the measure language, value sets for these examples are developed and are included in the eMeasure. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Additional details by data source are as follows:

For EHR:

HQMF eMeasure developed and is attached to this submission in field S.2a.

RISK ADJUSTMENT

No risk adjustment or risk stratification.

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator. (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.
3. Find the patients who qualify for denominator exclusions and subtract from the denominator.
4. From the patients within the denominator (after denominator exclusions have been subtracted from the denominator), find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator
5. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified (for this measure: decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons) and patient reason(s) (eg, patient declined, other patient reasons) for the patient not receiving the annual screening for HCV infection). If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage of patients with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.
If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. No diagram provided

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5.1 Identified measures: 0393 : Hepatitis C: Confirmation of Hepatitis C Viremia

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: The quality action performed in measure 0393 is confirming the hepatitis C antibody is present following initial testing and does not include the initial testing before diagnosis as a part of the quality action performed in the measure.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

3061 Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection

STEWARD

PCPI Foundation

DESCRIPTION

Percentage of patients aged 18 years and older with either (1) a positive HCV antibody test result and a positive HCV RNA test result 1or (2) a positive HCV antibody test result and an absent HCV RNA test result who are prescribed treatment or are referred to evaluation or treatment services

TYPE

Process

DATA SOURCE

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Not applicable.
No data collection instrument provided Attachment
HCVTreatmentFollowup_ValueSets_06152016-636028076980391166.xlsx

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic, Home Health, Post Acute/Long Term Care Facility :
Nursing Home/Skilled Nursing Facility, Other Domiciliary

NUMERATOR STATEMENT

Patients who are prescribed treatment or are referred to evaluation or treatment services

NUMERATOR DETAILS

For EHR:

Health Quality Measures Format (HQMF) eMeasure developed and is attached to this submission in field S.2a.

We have provided the following definitions and/or guidance for convenience; please see HQMF eMeasure for complete details related to the specification.

NUMERATOR GUIDANCE:

To meet the numerator for this measure, patients with an absent HCV RNA test result must be referred to evaluation or treatment services within 90 days following a positive HCV antibody test result, while patients with a positive HCV RNA test result must be either prescribed treatment or referred to evaluation or treatment services within 90 days following a positive HCV RNA test result.

This measure evaluates the proportion of patients who are receiving the appropriate follow up (either treatment or referral to a specialist) following a positive Hepatitis C screening test. In order to meet the measure, the reporting provider must have the laboratory test result present in the patient's medical record. On occasion, provider will view HCV screening results that were performed elsewhere and therefore results are not present in the EHR in a structured format. To

allow such tests to be applied to this measure, they should be entered into the EHR as a laboratory test in a manner consistent with the EHR in use. If the specific LOINC code of the test is not known, the entry should use the generic LOINC Panel code which is included in the HCV laboratory test value sets as outlined below:

If the provider does not know the exact HCV RNA test performed elsewhere, report the generic LOINC HCV RNA Panel code 75888-8, found in the value set titled, "HCV RNA Test".

If the provider does not know the exact HCV Antibody test performed elsewhere, report the generic LOINC HCV Ab Panel code, 75886-2, found in the value set titled, "HCV Antibody Test".

DENOMINATOR STATEMENT

All patients aged 18 years and older who are seen twice for any visit or who had at least one preventive visit with either (1) a positive HCV antibody test result and a positive HCV RNA test result or (2) a positive HCV antibody test result and an absent HCV RNA test result

DENOMINATOR DETAILS

For EHR:

HQMF eMeasure developed and is attached to this submission in field S.2a.

EXCLUSIONS

Denominator Exclusions:

Patients with a negative HCV RNA result, patients with a diagnosis of chronic hepatitis C

Denominator Exceptions:

Documentation of medical reason(s) for not prescribing treatment or being referred to evaluation or treatment services (eg, participation in a clinical trial, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons)

Documentation of patient reason(s) for not prescribing treatment or being referred to evaluation or treatment services (eg, patient declined, other patient reasons)

EXCLUSION DETAILS

The PCPI distinguishes between measure exceptions and measure exclusions. Exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (ie, the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision. For measure "Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection," exclusions include patients with a negative HCV RNA result, patients with a diagnosis of chronic hepatitis C. Exclusions, including applicable value sets, are included in the measure specifications.

Measure Exceptions

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of exception reasons for which a patient may be removed from the denominator of an individual

measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure “Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection,” exceptions may include medical reasons for not prescribing treatment or being referred to evaluation or treatment services such as participation in a clinical trial, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons or patient reason(s) for not prescribing treatment or being referred to evaluation or treatment services such as patient declined, other patient reasons. Where examples of exceptions are included in the measure language, value sets for these examples are developed and are included in the eMeasure. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients’ medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician’s exceptions data to identify practice patterns and opportunities for quality improvement.

Additional details by data source are as follows:

For EHR:

HQMF eMeasure developed and is attached to this submission in field S.2a.

RISK ADJUSTMENT

No risk adjustment or risk stratification.

STRATIFICATION

Consistent with CMS’ Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator. (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.
3. Find the patients who qualify for denominator exclusions and subtract from the denominator.
4. From the patients within the denominator (after denominator exclusions have been subtracted from the denominator), find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate

that the number of patients in the numerator is less than or equal to the number of patients in the denominator

5. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reasons for not prescribing treatment or being referred to evaluation or treatment services such as participation in a clinical trial, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons or patient reason(s) for not prescribing treatment or being referred to evaluation or treatment services such as patient declined, other patient reasons. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage of patients with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. No diagram provided

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5.1 Identified measures: Not applicable.

5a.1 Are specs completely harmonized? Not applicable.

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

3067 Human Immunodeficiency Virus (HIV) Infection Screening

STEWARD

Centers for Disease Control and Prevention

DESCRIPTION

Percentage of patients 15-65 years of age who were tested at least once for HIV.

TYPE

Process

DATA SOURCE

Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry Measure algorithm/logic can be consumed/applied in EHR or an electronic registry that pulls data from the EHR

No data collection instrument provided Attachment
HIVScreening_v4_Tue_Feb_24_22.20.27_CST_2015.xls

LEVEL

Facility, Clinician : Group/Practice

SETTING

Ambulatory Care : Clinician Office/Clinic

NUMERATOR STATEMENT

Patients with either documentation of an HIV test after their 15th birthday or evidence of HIV infection.

NUMERATOR DETAILS

The numerator should be reported according to the following 3 strata:

- Stratum 1: Patients with HIV Testing Performed;
- Stratum 2: Patients with prior diagnosis of HIV infection;
- Stratum 3: Patients with either HIV Testing Performed or prior diagnosis of HIV infection

In essence, Stratum 3 looks at the numerator population as a whole, while strata 1 and 2 look at two distinct, key sub-populations within the numerator population (i.e., those for whom testing evidence is direct and in the form of a lab order or result, and those for whom testing evidence is indirect or implicit, based on the presence of an HIV diagnosis code)

Detailed data elements and code sets available in Zipped Folder titled "HIVScreening_v4_Tue Feb 24 22.20.27 CST"

DENOMINATOR STATEMENT

Patients 15 to 65 years of age who had a visit in the measurement period*.

*The measurement period refers to a defined, 12 month interval that begins and ends prior to the measure calculation date.

DENOMINATOR DETAILS

Patients 15 to 65 years of age who had a visit in the measurement period. Note, the age range is inclusive of 15 but exclusive of 65: [15, 65)

Detailed data elements and code sets available in Zipped Folder titled "HIVScreening_v4_Tue Feb 24 22.20.27 CST"

EXCLUSIONS

None

EXCLUSION DETAILS

Not applicable

RISK ADJUSTMENT

No risk adjustment or risk stratification.

Not applicable

STRATIFICATION

The numerator should be reported according to the following 3 strata:

- Stratum 1: Patients with HIV Testing Performed;
- Stratum 2: Patients with prior diagnosis of HIV infection;
- Stratum 3: Patients with either HIV Testing Performed or prior diagnosis of HIV infection

In essence, Stratum 3 looks at the numerator population as a whole, while strata 1 and 2 look at two distinct, key sub-populations within the numerator population (i.e., those for whom testing evidence is direct and in the form of a lab order or result, and those for whom testing evidence is indirect or implicit, based on the presence of an HIV diagnosis code)

The proposed stratification allows individuals seeking to use the measure results (e.g., for performance assessment and comparison or quality improvement activities) to differentiate between physicians whose performance may be driven by their having a large number of persons living with HIV (PLWH) among their patients and physicians whose performance may be driven by their HIV screening practices vis-à-vis persons who are not known, at the time of their testing, to be living with HIV. It is not unreasonable to argue that comparing performance between the two groups of providers favors the former (those treating large numbers of PLWH) and disadvantages the latter (more typically primary care providers with limited experience—or occasion—to actively oversee the care of large numbers of PLWH): the combination of still evolving EHRs and an “ever” look back period necessarily favors calculations based on more typically recurrent or recently used data elements (i.e., diagnoses, relative to results for a specific lab).

Detailed data elements and code sets available in Zipped Folder titled “HIVScreening_v4_Tue Feb 24 22.20.27 CST”

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

1. Measure eligible population identified (defined as unity of a and b below)
 - a. Individuals within the following age range during the measurement period: $15 < X < 65$
 - b. Individuals who had at least one face-to-face encounter with the provider (individual, clinic, or health system, depending on measure use context) within the measurement period
 - c. NOTE: Specific dates marking beginning and end of measurement period to defined by user based on specific use context for measure, but length of measurement period expected to be 12 months (e.g., a calendar year)
2. Measure eligible population becomes the denominator for calculations
 - a. No additional exclusions applied
3. The numerator is then calculated by identifying all those individuals in the denominator for which there is evidence of either of the following in their electronic health records:
 - a. An HIV laboratory test performed at least once since the individual turned 15 and before the end of the measurement period (NOTE: the test need not have been performed during the measurement period, but documentation that such a test had been performed should have been available for any provider to reference/verify during the measurement period)
 - b. Documentation of an HIV diagnosis at any point prior to the end of the measurement period
 - c. NOTE: The measure can be calculated (and results stratified) separately based on whether an individual is counted towards the numerator on the basis of criterion a, criterion b, or either a or b. However, for reporting purposes, the numerator is generally expected to consist of all those individuals in the denominator who meet criterion 3a OR 3b.

4. Measure score is calculated by dividing the numerator by the denominator and then converting the results to a percentage. No diagram provided

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5.1 Identified measures: Not applicable.

5a.1 Are specs completely harmonized? Not applicable.

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

3070 Preventive Care and Screening: Influenza Immunization

STEWARD

PCPI Foundation

DESCRIPTION

Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

TYPE

Process

DATA SOURCE

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Not applicable
No data collection instrument provided Attachment CMS147v6_Preventive-Influenza_PCPI_valuesets_APRIL2016.xlsx

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Other Domiciliary

NUMERATOR STATEMENT

Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

NUMERATOR DETAILS

For EHR:

Health Quality Measures Format (HQMF) eMeasure developed and is attached to this submission in field S.2a.

We have provided the following definitions and/or guidance for convenience; please see HQMF eMeasure for complete details related to the specification.

NUMERATOR DEFINITION:

Previous Receipt - receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st)

DENOMINATOR STATEMENT

All patients aged 6 months and older seen for a visit between October 1 and March 31

DENOMINATOR DETAILS

For EHR:

HQMF eMeasure developed and is attached to this submission in field S.2a.

We have provided the following definitions and/or guidance for convenience; please see HQMF eMeasure for complete details related to the specification.

DENOMINATOR GUIDANCE:

The timeframe for the visit during the "Encounter, Performed: Encounter-Influenza" or "Procedure, Performed: Peritoneal Dialysis" or "Procedure, Performed: Hemodialysis" in the Population Criteria-Denominator, refers to the influenza season defined by the measure: October through March (October 1 for the year prior to the start of the reporting period through March 31 during the reporting period). The "Encounter-Influenza" Grouping OID detailed in the data criteria section below is comprised of several individual OIDs of different encounter types. The individual OIDs are included in the value set and should be reviewed to determine that an applicable visit occurred during the timeframe for "Encounter, Performed: Encounter-Influenza" as specified in the denominator.

To enable reporting of this measure at the close of the reporting period, this measure will only assess the influenza season that ends in March of the reporting period. The subsequent influenza season (ending March of the following year) will be measured and reported in the following year.

To account for the majority of reporting years' appropriate flu season duration, the measure logic will look at the first 89 days of the measurement period for the appropriate criteria and actions to be present/performed (January 1 through March 31). The measure developer believes it is best to keep the logic as static as possible from one reporting year to the next. Therefore, during leap years, only encounters that occur through March 30 will be counted in the denominator.

EXCLUSIONS

Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons)

Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons)

Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons)

EXCLUSION DETAILS

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient

characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure on Preventive Care and Screening: Influenza Immunization, exceptions may include medical reason(s) (eg, patient allergy); patient reason(s) (eg, patient declined); or system reason(s) for the patient not receiving influenza immunization (eg, vaccine not available). Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Additional details by data source are as follows:

For EHR:

HQMF eMeasure developed and is attached to this submission in field S.2a.

RISK ADJUSTMENT

No risk adjustment or risk stratification

No risk adjustment or risk stratification

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.
3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator
4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions

have been specified [for this measure: medical reason(s) (eg, patient allergy) patient reason(s) (eg, patient declined) or system reason(s) for the patient not receiving influenza immunization (eg, vaccine not available, other system reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. No diagram provided

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5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

0226 : Influenza Immunization in the ESRD Population (Facility Level)

0039 : Flu Vaccinations for Adults Ages 18 and Older

0431 : Influenza Vaccination Coverage Among Healthcare Personnel

0522 : Influenza Immunization Received for Current Flu Season (Home Health)

1659 : Influenza Immunization

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Related measures have differing target populations from measure 0041 Preventive Care and Screening: Influenza Immunization. Measure #0041 is intended to evaluate adherence to the current recommendations of the Advisory Committee on Immunization Practices for all persons aged ≥ 6 months who do not have contraindications. Measure #0039 - Flu Vaccinations for Adults ages 18 and Older focuses on the self-reported receipt of influenza vaccination among adults using the CAHPS survey. Measure #0226 – Influenza Immunization in the ESRD Population is a facility level measure focused on influenza vaccination among end stage renal disease (ESRD) patients receiving hemodialysis or peritoneal dialysis. Measure #0431 - Influenza Vaccination Coverage Among Healthcare Personnel focuses on influenza vaccination among healthcare workers. Measure #0522 Influenza Immunization Received for Current Flu Season (Home Health) evaluates influenza immunization during home health episodes of care. Measure # 0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay) applies to patients of Inpatient Rehabilitation Facilities and Long-Term Care Hospitals, and to short-stay nursing home residents. Measure #0681 - Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay) assess influenza vaccination among long-stay nursing facility residents. Measure #1659 Influenza Immunization is limited to the assessment of influenza vaccination upon discharge from the inpatient setting.

5b.1 If competing, why superior or rationale for additive value: N/A

3071 Follow-up Referral after Positive Developmental Screen

STEWARD

Northwestern University

DESCRIPTION

Percentage of patients aged 6 to 36 months who were referred for follow-up care within 7 calendar days of receiving a positive developmental screening result.

TYPE

Process

DATA SOURCE

Electronic Clinical Data : Electronic Health Record During the chart review process, abstracted data elements for the measure can be entered into a data collection form. Please see the data collection form attached in section S.25 for the elements required to calculate this measure.

Available in attached appendix at A.1 No data dictionary

LEVEL

Clinician : Group/Practice, Clinician : Individual, Integrated Delivery System

SETTING

Ambulatory Care : Clinician Office/Clinic

NUMERATOR STATEMENT

Patients who received a referral for follow-up care (1) by the screening clinician within 7 calendar days of receiving a positive developmental screening result (2)

NUMERATOR DETAILS

1) Referral for follow-up care is defined as the formal event by which the clinician provides a referral to the patient family (and does not include any further steps in the process like securing the appointment, confirming the appointment attendance, etc.) and refers the patient and family for further evaluation or to any type of therapy, intervention, or education to mitigate developmental delays. A referral can be within the medical home or outside the medical home. A referral can also include a form of watchful waiting by which the clinician offers practice-based intervention(s) and schedules a follow-up visit within 3 months. Some referral types are listed below but this list is not exhaustive:

- Part C, Early Intervention Program
- Referral for Follow-up Testing
- Home Visiting for 0-5
- Physical Therapist
- Occupational Therapist
- Speech/Language Pathologist
- Medical Home Clinician Internal
- Specialty Clinician External
- Early Head Start

- Network Care Manager
- Family-to-Family Support
- Hearing and Vision Specialists
- Mental Health Specialist

2) A positive developmental screening result refers to a result from use of a validated developmental screening tool that indicates the patient tests positive for risk of a developmental delay.

DENOMINATOR STATEMENT

All patients aged 6 months to 36 months who received a positive developmental screening result through the use of a validated screening tool or an indication from the family that there is a developmental concern.

DENOMINATOR DETAILS

N/A

EXCLUSIONS

Patients who did not receive a developmental screen using a validated developmental screening tool or who have already received or are receiving therapy, intervention, or education that would also be applicable for developmental delay follow-up care.

EXCLUSION DETAILS

Chart abstractors were instructed to look for developmental screening tool and assess whether it was a validated tool, they were provided lists of validated tools, and were asked to evaluate whether patient was already receiving developmental delay follow-up care.

RISK ADJUSTMENT

No risk adjustment or risk stratification.

N/A

STRATIFICATION

This measure does not require stratification or risk adjustment.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

To calculate this measure as a chart review measure, please use the following algorithm:

- 1) Select charts by identifying patients with CPT code 96110 and well-child visit codes 99381, 99382, and 99392
- 2) Review chart for denominator criteria by looking for evidence of the use of a validated screening tool for conducting the developmental screen and a positive developmental screening result or an indication of concern from the parent or a clinician, if possible use Natural Language Processing (NLP) and the attached suggested phrases (Attachment S.18 NLP)
- 3) Collect demographics and elements for equity assessment including gender, race/ethnicity, language preference, insurance status/type, and age

- 4) Review chart and document measure elements (denominator, exclusion criteria, and numerator) in the chart abstraction tool
- 5) Note relevant comments
- 6) Use the chart abstraction tool to identify whether each record meets the denominator and the numerator criteria. Available in attached appendix at A.1

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5.1 Identified measures: 1448 : Developmental Screening in the First Three Years of Life

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: While there is a developmental screening NQF measure that has been endorsed, the NQF measure focuses on the occurrence of developmental screens using a validated tool. This proposed measure focuses on the child receiving the recommended follow-up care resulting from a positive developmental screen. The quality of care evaluated by this measure includes aspects of health care provision that are fundamental to child wellbeing and are often done as routine care. Additionally, as part of a Developmental Screening measure-set there are 2 additional measure that assess different aspects of developmental screening follow-up: Discussion with Patient Family Following a Developmental Screen and Follow-up Referral Tracking. Each of these measures are measuring different care processes and there are no conflicts with the Initial Core measure or the measure submitted here. Additionally, this measure should not increase data collection burden.

5b.1 If competing, why superior or rationale for additive value: N/A

3086 Population Level HIV Viral Load Suppression

STEWARD

Centers for Disease Control and Prevention

DESCRIPTION

Percentage of persons > 13 years of age with diagnosed HIV infection who are virally suppressed in the measurement year.

TYPE

Intermediate Clinical Outcome

DATA SOURCE

Other Data come from the submissions to the National HIV Surveillance System. Submissions come in the form of updated case report forms, and case report forms are populated through a combination of passive (e.g., receipt of lab test results, which labs are statutorily mandated to report) and active (review of EHR or clinical record) surveillance methods.

Available in attached appendix at A.1 No data dictionary

LEVEL

Population : State

SETTING

Other Not applicable, measure is on population level.

NUMERATOR STATEMENT

Number of HIV-diagnosed persons, aged ≥ 13 years and alive at the end of the measurement year, whose most recent viral load test showed that HIV viral load was suppressed

NUMERATOR DETAILS

Information is obtained from the National HIV Surveillance System. Data from jurisdictions with complete reporting of CD4 and viral load test results to CDC during the measurement period are used to assess viral suppression. Viral load results are reported to state/local health departments. The results are added to the enhanced HIV/AIDS Reporting System (eHARS) case record for persons with diagnosed HIV and transferred to CDC. HIV Case Report form is attached in appendix.

DENOMINATOR STATEMENT

Number of persons ≥ 13 years with HIV infection diagnosed by previous year and alive at year end.

DENOMINATOR DETAILS

Information is obtained from the National HIV Surveillance System. All 50 states, the District of Columbia, and 6 U.S. dependent areas (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the U.S. Virgin Islands) have laws or regulations that require confidential reporting to the jurisdiction (not to CDC), by name, adults, adolescents, and children with confirmed diagnoses of HIV infection. After the removal of personally identifiable information, data from these reports are submitted to CDC.

EXCLUSIONS

Definition excludes persons with HIV diagnosed during the measurement year and persons no longer alive at the end of measurement year.

EXCLUSION DETAILS

Year of confirmed diagnosis date = measure year; vital status = dead and death date (year) is \leq measure year.

RISK ADJUSTMENT

No risk adjustment or risk stratification.

Not applicable

STRATIFICATION

For current measure application at sub-national level, data are stratified by jurisdiction of residence (for 2012, 27 states and the District of Columbia).

National data are typically also stratified and presented by sex/gender, transmission risk category, age, and race/ethnicity (specific variables and code sets in case form supplied in appendix--results available in tables 5a/5b of appended report, cdc-hiv-surveillancereport_vol20_no2). States with complete viral load (VL) reporting can also conduct such stratification locally, but these data are not required for current public reporting activities.

TYPE SCORE

Rate/proportion better quality = score within a defined interval

ALGORITHM

Comparison of percentage to benchmark, which is established in the National HIV/AIDS Strategy: Updated to 2020.

Annual Targets Under NHAS

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
43.4%	45.2%	47.1%	48.9%	52.6%	56.2%	59.9%	63.5%	69.0%	74.5%	80.0% No diagram provided

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5.1 Identified measures: 2082 : HIV viral load suppression

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: In its 2015 report, Vital Signs: Core Metrics for Health and Health Care Progress, the organization then known as the Institute of Medicine (now the National Academy of Medicine) highlighted the importance of “ greater alignment and harmonization in health system measurement [as] the various measurement efforts remain broadly uncoordinated both horizontally, or across various activities, and vertically, in terms of consistent and comparable measurements at the national, state, local, and institutional levels.” (Emphasis added). By adding CDC’s population level viral load suppression (VLS) measure to its measurement stable, NQF will successfully advance precisely the sort of “vertical alignment” that the IOM recommends—at least, in the HIV prevention and care arenas. The proposed CDC VLS measure and the existing HRSA VLS measure (which CDC also supports and helped HRSA advance through the original NQF endorsement process) are fully complementary: the measures are conceptually aligned (and grounded in the same source of recommendations: specifically, the Department of Health and Human Services’ Guideline for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents) as well as substantively and methodologically aligned wherever possible given the necessary differences in data sources and measurement entities. Critically, both measures define viral load suppression in the same manner (<200 copies/mL at the most recent viral load test, where “most recent” is tantamount to the last VL test performed in the measurement year), and both use similar inclusion and exclusion criteria (e.g., individual was diagnosed in the year preceding the measurement year). Where differences exist, they are generally minor and reflect the different “levels” to which the two measures are to be applied (i.e., states for the CDC measure; clinicians and clinical facilities for the HRSA measure), as well as the different data sources that contribute to calculation (i.e., surveillance cast report forms submitted to CDC for the CDC measure; administrative or claims data and electronic records for the HRSA measure).

5b.1 If competing, why superior or rationale for additive value: In its 2015 report, Vital Signs: Core Metrics for Health and Health Care Progress, the organization then known as the Institute of Medicine (now the National Academy of Medicine) highlighted the importance of “ greater alignment and harmonization in health system measurement [as] the various measurement efforts remain broadly uncoordinated both horizontally, or across various activities, and vertically, in terms of consistent and comparable measurements at the national, state, local, and institutional levels.” (Emphasis added). By adding CDC’s population level viral load suppression (VLS) measure to its measurement stable, NQF will successfully advance precisely the sort of

“vertical alignment” that the IOM recommends—at least, in the HIV prevention and care arenas. The proposed CDC VLS measure and the existing HRSA VLS measure (which CDC also supports and helped HRSA advance through the original NQF endorsement process) are fully complementary: the measures are conceptually aligned (and grounded in the same source of recommendations: specifically, the Department of Health and Human Services’ Guideline for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents) as well as substantively and methodologically aligned wherever possible given the necessary differences in data sources and measurement entities. Critically, both measures define viral load suppression in the same manner (<200 copies/mL at the most recent viral load test, where “most recent” is tantamount to the last VL test performed in the measurement year), and both use similar inclusion and exclusion criteria (e.g., individual was diagnosed in the year preceding the measurement year). Where differences exist, they are generally minor and reflect the different “levels” to which the two measures are to be applied (i.e., states for the CDC measure; clinicians and clinical facilities for the HRSA measure), as well as the different data sources that contribute to calculation (i.e., surveillance cast report forms submitted to CDC for the CDC measure; administrative or claims data and electronic records for the HRSA measure).

3087 Completion of a Malnutrition Screening within 24 hours of Admission

STEWARD

Avalere Health/Academy of Nutrition & Dietetics

DESCRIPTION

Completion of a malnutrition screening to determine if a patient is at-risk for malnutrition, within 24 hours of admission to the hospital

TYPE

Process

DATA SOURCE

Electronic Clinical Data : Electronic Health Record Electronic Health Record
No data collection instrument provided Attachment
MalnutritionScreening_v4_3_Tue_Jul_12_21.03.46_CDT_2016.xls

LEVEL

Facility

SETTING

Hospital/Acute Care Facility

NUMERATOR STATEMENT

Patients in the denominator who have a completed malnutrition screening documented in the medical record within 24 hours of admission to the hospital. For the purposes of this measure, it is recommended that a malnutrition screening be performed using a validated screening tool which may include but is not limited to one of the following validated tools:

Malnutrition Screening Tool (MST) (Wu, 2012), Nutrition Risk Classification (NRC) (Kovacevich, 1997), Nutritional Risk Index (NRI) (Honda, 2016), Nutritional Risk Screening 2002 (NRS-2002) (Bauer, 2005), Short Nutrition Assessment Questionnaire (SNAQ) (Pilgrim, 2016).

Bauer JM, Vogl T, Wicklein S, Trögner J, Mühlberg W, Sieber CC. Comparison of the Mini Nutritional Assessment, Subjective Global Assessment, and Nutritional Risk Screening (NRS 2002) for nutritional screening and assessment in geriatric hospital patients. *Z Gerontol Geriatr.* 2005;38(5):322-7.

Kovacevich DS, Boney AR, Braunschweig CL, Perez A, Stevens M. Nutrition risk classification: a reproducible and valid tool for nurses. *Nutr Clin Pract.* 1997;12(1):20-5.

Honda Y, Nagai T, Iwakami N, et al. Usefulness of Geriatric Nutritional Risk Index for Assessing Nutritional Status and Its Prognostic Impact in Patients Aged ≥65 Years With Acute Heart Failure. *Am J Cardiol.* 2016;

Pilgrim AL, Baylis D, Jameson KA, et al. Measuring Appetite with the Simplified Nutritional Appetite Questionnaire Identifies Hospitalised Older People at Risk of Worse Health Outcomes. *J Nutr Health Aging.* 2016;20(1):3-7.

Wu ML, Courtney MD, Shortridge-baggett LM, Finlayson K, Isenring EA. Validity of the malnutrition screening tool for older adults at high risk of hospital readmission. *J Gerontol Nurs.* 2012;38(6):38-45.

NUMERATOR DETAILS

Patients to be included in the numerator are identified via one data element that using the following value set:

1. Value Set Name: Malnutrition Risk Screening (OID: 2.16.840.1.113762.1.4.1095.40)

The difference between the timestamp of the above data element and the time from admission is calculated, patients meet the criteria for the numerator when the difference in time calculated is less than 24 hours.

Logic for calculating the numerator is included in the eMeasure specification.

DENOMINATOR STATEMENT

All patients age 18 years and older at time of admission who are admitted to an inpatient hospital

DENOMINATOR DETAILS

All patients 18 years and older who are admitted to the inpatient acute care facility using the following value set for the data element:

1. Value Set Name: Hospital Measures – Encounter Inpatient (OID: 2.16.840.1.113762.1.4.1095.40)

Logic for calculating the denominator is included in the eMeasure specification.

EXCLUSIONS

No denominator exclusions for this measure.

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

No risk adjustment or risk stratification.

N/A

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

The measure logic is provided in the eMeasure specification.

Performance is calculated using the following steps:

1. Identification of initial population which includes all adults aged 18 years and older who are admitted into an inpatient acute care facility
2. From those patients in the initial population, identify patients who meet the denominator criteria
3. From the remaining subset of patients who remain in the denominator, identify those who meet numerator criteria by calculating time between the time stamp of malnutrition screening and the time stamp of admission.
4. Patient records with a calculation resulting in <24 hours should be assigned to the numerator.
5. Final measure calculation will be a proportion of patients who appropriate meet numerator criteria over the denominator population (Numerator/Denominator) No diagram provided

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5.1 Identified measures: 3088 : Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening

3089 : Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment

3090 : Appropriate Documentation of a Malnutrition Diagnosis

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable.

5b.1 If competing, why superior or rationale for additive value: N/A

3088 Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening

STEWARD

Academy of Nutrition and Dietetics

DESCRIPTION

Patients age 65 years and older identified as at-risk for malnutrition based on a malnutrition screening who have a nutrition assessment documented in the medical record within 24 hours of the most recent malnutrition screening.

TYPE

Process

DATA SOURCE

Electronic Clinical Data : Electronic Health Record

No data collection instrument provided Attachment

NutritionAssessmentin24hours_v4_3_Tue_Jul_12_23.58.52_CDT_2016.xls

LEVEL

Facility

SETTING

Hospital/Acute Care Facility

NUMERATOR STATEMENT

Patients in the denominator who have a nutrition assessment documented in the medical record within 24 hours of the most recent malnutrition screening.

Recommended nutrition assessment tools include: Subjective Global Assessment (Detsky, 1987), Patient Generated Subjective Global Assessment (Bauer, 2002), Nutrition-Focused Physical Exam (White, 2012)

Detsky AS, McLaughlin JR, Baker JP, et al. What is subjective global assessment of nutritional status?. JPEN J Parenter Enteral Nutr. 1987;11(1):8-13.

Bauer J, Capra S, Ferguson M. Use of the scored Patient-Generated Subjective Global Assessment (PG-SGA) as a nutrition assessment tool in patients with cancer. Eur J Clin Nutr. 2002;56(8):779-85.

White JV, Guenter P, Jensen G, et al. Consensus statement: Academy of Nutrition and Dietetics and American Society for Parenteral and Enteral Nutrition: characteristics recommended for the identification and documentation of adult malnutrition (undernutrition). JPEN J Parenter Enteral Nutr. 2012;36(3):275-83.

NUMERATOR DETAILS

Patients to be included in the numerator are identified via one data element that using the following value set:

1. Value Set Name: Malnutrition Assessment (OID: 2.16.840.1.113762.1.4.1095.29)

The difference between the time stamp of the above data element and the time stamp of the completion of the malnutrition screening is calculated, patients meet the criteria for the numerator when the difference in time calculated is less than 24 hours.

Logic for calculating the numerator is included in the eMeasure specification.

DENOMINATOR STATEMENT

Patients age 65 years and older who were identified as at-risk for malnutrition upon completing a malnutrition screening.

DENOMINATOR DETAILS

All patients aged 65 years and older who were admitted into acute inpatient care and who were found to be at risk after completion of a malnutrition screening includes the following value set for the data element:

1. Value Set Name: Malnutrition Risk Screening (result: Malnutrition Screening At Risk) (OID: 2.16.840.1.113762.1.4.1095.38)

Logic for calculating the denominator is included in the eMeasure specification.

EXCLUSIONS

Denominator exclusions include:

- Length of Stay <24 hours

EXCLUSION DETAILS

The following data elements are used to calculate the denominator exclusions:

- Length of Stay <24 hours
 - o Definition: Patients whose length of stay is less than 24 hours

RISK ADJUSTMENT

No risk adjustment or risk stratification

N/A

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

The measure logic is provided in the eMeasure specification.

Performance is calculated using the following steps:

1. Identification of initial population which includes all adults aged 65 years and older who are admitted into an inpatient acute care facility
2. From those patients in the initial population, identify patients who meet the denominator criteria by assigning patients identified as at-risk of malnutrition with a completed malnutrition screening
3. From the remaining subset of patients in the denominator, identify those who meet numerator criteria by calculating time between the time stamp of nutrition assessment and the time stamp of malnutrition screening.
4. Patient records with a calculation resulting in <24 hours should be assigned to the numerator.
5. Final measure calculation will be a proportion of patients who appropriate meet numerator criteria over the denominator population (Numerator/Denominator) No diagram provided

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5.1 Identified measures: 3087 : Completion of a Malnutrition Screening within 24 hours of Admission

3089 : Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment

3090 : Appropriate Documentation of a Malnutrition Diagnosis

- 5a.1 Are specs completely harmonized? Yes
- 5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable.
- 5b.1 If competing, why superior or rationale for additive value: N/A

3089 Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment

STEWARD

Avalere Health/Academy of Nutrition & Dietetics

DESCRIPTION

A nutrition care plan for those patients who are found to be malnourished based on a completed nutrition assessment with findings of malnutrition

TYPE

Process

DATA SOURCE

Electronic Clinical Data : Electronic Health Record Electronic Health Record
No data collection instrument provided Attachment
NutritionCarePlan_v4_3_Mon_Jul_18_14.31.05_CDT_2016.xls

LEVEL

Facility

SETTING

Hospital/Acute Care Facility

NUMERATOR STATEMENT

Patients with a nutrition care plan documented in the patient's medical record.
Care plan components include, but are not limited to: Completed assessment results; data and time stamp; treatment goals; prioritization based on treatment severity; prescribed treatment/intervention; identification of members of the Care Team, timeline for patient follow-up

NUMERATOR DETAILS

Data Elements for Chart Abstraction:

The following data element is used to calculate properly assign patients to the numerator:

1. Nutrition Care Plan: Document presence of a nutrition care plan in the patient medical record for patients who have findings of malnutrition pulled from the electronic measure specifications. A nutrition care plan is defined as a document outlining comprehensive planned actions with the intention of impacting nutrition-related factors affecting patient health status.

Data Elements for Chart Abstraction:

The following data element is used to calculate properly assign patients to the denominator:

1. Nutrition Assessment Findings: Document presence of the findings of the nutrition assessment as indicated by the dietitian who assessed the patient. Nutrition assessment findings

typically outline the type of malnutrition present which forms the basis of the malnutrition diagnosis.

DENOMINATOR STATEMENT

Patients from the initial population with completed nutrition assessment documented in their medical record with findings of malnutrition.

DENOMINATOR DETAILS

The data elements for this measure are a combination of electronic data extracted from the EHR with the measure specifications and a subset of data elements that require chart abstraction:

Electronic Data Elements:

All patients 65 years and older who are admitted to the inpatient acute care facility using the following value set for the data element:

1. Value Set Name: Hospital Measures – Encounter Inpatient (OID: 2.16.840.1.113762.1.4.1095.40)

Patients to be included in the numerator are those who have a completed nutrition assessment identified in the following data element described in the value set identified below:

2. Value Set Name: Malnutrition Assessment (OID: 2.16.840.1.113762.1.4.1095.29)

EXCLUSIONS

Patients with a length of stay of <24 hours and patients who left against medical advice should be excluded from the measure denominator due to their very short inpatient stay.

EXCLUSION DETAILS

The following data elements are used to calculate the denominator exclusions:

- Length of Stay <24 hours

Definition: Patients whose length of stay is less than 24 hours

- Left Against Medical Advice

Definition: Patients whose discharge status is that they left against medical advice

RISK ADJUSTMENT

No risk adjustment or risk stratification.

N/A

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

The measure logic to collect electronic data from the EHR is provided in the eMeasure specification, additional data collection in the form of chart abstraction is also described below.

Performance is calculated using the following steps:

1. Identification of initial population which includes all adults aged 65 years and older who are admitted into an inpatient acute care facility is assessed by implementing the eMeasure specifications
2. From those patients in the initial population, identify patients who meet the denominator criteria using the data element, Malnutrition Assessment built into the eMeasure logic
 - a. After running electronic specification to collect electronic health data, review each patient record from the denominator who have a nutrition assessment documented in the record
 - b. Patients must have a nutrition assessment documented in the electronic health record with findings of malnutrition in order to qualify for the denominator
3. Identify and remove patients who should be excluded from the denominator using exclusion criteria
4. From the remaining subset of patients who remain in the denominator, identify those who meet numerator criteria by reviewing the patient record to record if a nutrition care plan was implemented in the patient's medical record.
5. Final measure calculation will be a proportion of patients who appropriately meet numerator criteria by having a documented nutrition care plan over the denominator population of patients who have completed – any denominator exclusions

$$\left[\frac{\text{Numerator}}{\text{Denominator} - \text{Denominator Exclusions}} \right]$$
 No diagram provided

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5.1 Identified measures: 3087 : Completion of a Malnutrition Screening within 24 hours of Admission

3088 : Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening

3090 : Appropriate Documentation of a Malnutrition Diagnosis

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Although this measure is not explicitly grouped it is related to a set of three other malnutrition measures that were developed concurrently and focus on the evidence-based nutrition care process to capture malnutrition quality improvement. This measure is the third of four measures addressing target areas of malnutrition care beginning with nutrition screening to identify patients at-risk of malnutrition leading to nutrition intervention for patients who were diagnosed with malnutrition. There is significant evidence that performing the nutrition care process effectively is associated with improved patient outcomes, hence the reason that the developer has begun addressing quality in nutrition with related process measures. Screening for risk of malnutrition is the first step in the nutrition care process, leading to the assessment of at-risk patients. A registered dietitian can then make a recommendation for findings of malnutrition based on the assessment. Findings from the assessment lead to the determination of a malnutrition diagnosis (in conjunction with the physician), development of a nutrition care plan, and provision of the most appropriate interventions to address the patient's nutritional status (Nutrition care process and model part I: the 2008 update. J Am Diet Assoc. 2008;108(7):1113-7). This individual measure is being submitted as part of a suite of measures focused on malnutrition care, with the goal of creating a full composite measure representing a Global Malnutrition Score. It is

believed that evidence from implementation of this suite of performance measures can eventually inform such a Global Malnutrition Score.

5b.1 If competing, why superior or rationale for additive value: N/A

3090 Appropriate Documentation of a Malnutrition Diagnosis

STEWARD

Avalere Health/Academy of Nutrition & Dietetics

DESCRIPTION

Appropriate documentation of a malnutrition diagnosis for those patients who are found to be malnourished based on a nutrition assessment.

TYPE

Process

DATA SOURCE

Electronic Clinical Data : Electronic Health Record Electronic Health Record

No data collection instrument provided Attachment

MalnutritionDiagnosis_v4_3_Wed_Jul_13_13.03.35_CDT_2016.xls

LEVEL

Facility

SETTING

Hospital/Acute Care Facility

NUMERATOR STATEMENT

Patients with a documented diagnosis of malnutrition.

NUMERATOR DETAILS

Electronic Data Elements:

Patients to be included in the numerator are those who have a documented malnutrition diagnosis identified by the following data element described in the value set listed below:

1. Value Set Name: Nutrition Diagnosis (OID: 2.16.840.1.113762.1.4.1095.10)

DENOMINATOR STATEMENT

Patients age 65 years and older admitted to inpatient care who have a completed nutrition assessment documented in their medical record with a finding of malnutrition.

DENOMINATOR DETAILS

Electronic Data Elements:

All patients 65 years and older who are admitted to the inpatient acute care facility using the following value set for the data element:

1. Value Set Name: Hospital Measures – Encounter Inpatient (OID: 2.16.840.1.113762.1.4.1095.40)

Patients to be included in the numerator are those who have a completed nutrition assessment identified in the following data element described in the value set identified below:

2. Value Set Name: Malnutrition Assessment (OID: 2.16.840.1.113762.1.4.1095.29)

Data Elements for Chart Abstraction:

The following data element is used to calculate the remainder of the denominator, patients who have nutrition assessment documented in their medical record would meet denominator criteria only if there is a finding of malnutrition documented. The result of the nutrition assessment should be chart abstracted via a manual review of the patient's medical record.

EXCLUSIONS

Patients with a length of stay of <24 hours should be excluded from the measure denominator due to their very short inpatient stay, and the length of time typically required for the full nutrition care process (screening and assessment) to be implemented.

EXCLUSION DETAILS

The following data elements are used to calculate the denominator exclusions:

- Length of Stay <24 hours
- o Definition: Patients whose length of stay is less than 24 hours

RISK ADJUSTMENT

No risk adjustment or risk stratification.

N/A

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

The measure logic to collect electronic data from the EHR is provided in the eMeasure specification.

Performance is calculated using the following steps:

1. Identification of initial population which includes all adults aged 65 years and older who are admitted into an inpatient acute care facility
2. From those patients in the initial population, identify patients who meet the denominator criteria
 - a. After running electronic specification to collect data on complete nutrition assessments, review each patient record from the denominator that has documented malnutrition findings as a result of the nutrition assessment
 - b. Patients must have a nutrition assessment documented in the electronic health record
3. Identify and remove patients who should be excluded from the denominator using exclusion criteria

4. From the subset of patients who remain in the denominator, identify those who meet numerator criteria by identifying those who had a nutrition diagnosis pulled from the eMeasure specifications
5. Final measure calculation will be a proportion of patients who appropriate meet numerator criteria over the denominator population – any denominator exclusions
[Numerator/(Denominator – Denominator Exclusions) No diagram provided

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5.1 Identified measures: 3087 : Completion of a Malnutrition Screening within 24 hours of Admission

3088 : Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening

3089 : Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Although this measure is not explicitly grouped it is related to a set of three other malnutrition measures that were developed concurrently and focus on the evidence-based nutrition care process to capture malnutrition quality improvement. This measure is the final of four measures addressing target areas of malnutrition care beginning with nutrition screening to identify patients at-risk of malnutrition leading to nutrition intervention incorporated into a nutrition care plan for patients who were diagnosed with malnutrition. There is significant evidence that performing the nutrition care process effectively is associated with improved patient outcomes, hence the reason that the developer has begun addressing quality in nutrition with related process measures. Screening for risk of malnutrition is the first step in the nutrition care process, leading to the assessment of at-risk patients. A registered dietitian can then make a recommendation for findings of malnutrition based on the assessment. Findings from the assessment lead to the determination of a malnutrition diagnosis (in conjunction with the physician), development of a nutrition care plan, and provision of the most appropriate interventions to address the patient's nutritional status (Nutrition care process and model part I: the 2008 update. J Am Diet Assoc. 2008;108(7):1113-7). This individual measure is being submitted as part of a suite of measures focused on malnutrition care, with the goal of creating a full composite measure representing a Global Malnutrition Score. It is believed that evidence from implementation of this suite of performance measures can eventually inform such a Global Malnutrition Score.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

Appendix F1: Related and Competing Measures (tabular format)

Comparison of NQF #0039, NQF #0041, NQF #0226, NQF #0431, NQF #0680, NQF #0681, NQF #1659, and NQF #3070

	0039 Flu Vaccinations for Adults Ages 18 and Older	0041 Preventive Care and Screening: Influenza Immunization	0226 Influenza Immunization in the ESRD Population (Facility Level)	0431 Influenza Vaccination Coverage Among Healthcare Personnel	0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)	0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)	1659 Influenza Immunization	3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)
Steward	National Committee for Quality Assurance	PCPI Foundation	Kidney Care Quality Alliance	Centers for Disease Control and Prevention	Centers for Medicare & Medicaid Services	Centers for Medicare & Medicaid Services	Centers for Medicare and Medicaid Services	PCPI Foundation
Description	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure is collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, and commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Percentage of end stage renal disease (ESRD) patients aged 6 months and older receiving hemodialysis or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31 who either received, were offered and declined, or were determined to have a medical contraindication to the influenza vaccine.	Percentage of healthcare personnel (HCP) who receive the influenza vaccination.	The measure reports the percentage of short-stay residents or patients who are assessed and appropriately given the seasonal influenza vaccine during the most recently-completed influenza season. The influenza vaccination season (IVS) is defined as beginning on October 1, or when the vaccine first becomes available*, and ends on March 31 of the following year. This measure is based on the NQF's National Voluntary Standards for Influenza and Pneumococcal Immunizations. The measure is the aggregate of three separately calculated submeasures to reflect the process by which a resident or patient is assessed and appropriately given the influenza vaccination during the current or most recent influenza season. The three submeasures are as follows: <ul style="list-style-type: none"> residents or patients who received the influenza vaccine during the most recently completed influenza season, either in the facility/hospital or outside the facility/hospital (NQF #0680a); 	This measure reports the percentage of long-stay residents, 180 days of age and older, who were in a nursing facility for at least one day during the most recently completed influenza vaccination season (IVS), and who were assessed and appropriately given the seasonal influenza vaccine. The IVS is defined as beginning on October 1 and ends on March 31 of the following year. The measure is the aggregate of three separately calculated submeasures to reflect the process by which a resident is assessed and appropriately given the influenza vaccination during the current or most recent influenza season. The three submeasures are as follows: <ul style="list-style-type: none"> resident received the influenza vaccine during the current or most recent influenza season, either in the facility or outside the facility (NQF #0681a); resident was offered and declined the seasonal influenza vaccine (NQF #0681b); and resident was ineligible to receive the seasonal influenza vaccine due to contraindication(s) (e.g., anaphylactic 	Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

	0039 Flu Vaccinations for Adults Ages 18 and Older	0041 Preventive Care and Screening: Influenza Immunization	0226 Influenza Immunization in the ESRD Population (Facility Level)	0431 Influenza Vaccination Coverage Among Healthcare Personnel	0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)	0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)	1659 Influenza Immunization	3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)
					<ul style="list-style-type: none"> residents or patients who were offered and declined the seasonal influenza vaccine (NQF #0680b); residents or patients who were ineligible to receive the seasonal influenza vaccine due to contraindication(s) (e.g., anaphylactic hypersensitivity to eggs or other components of the vaccine, see http://www.cdc.gov/flu/professionals/vaccination/vax-summary.htm) (NQF #0680c). <p>*Note: While the IVS officially begins when the vaccine becomes available, which may be before October 1, the denominator time window for the quality measure and references to the IVS for the denominator specification is from October 1 to March 31 of the following year. The numerator time window and references to the IVS in the numerator specifications may include patients and residents who are assessed and offered the vaccine before October 1. This is based on how the influenza items were coded by the facility.</p> <p>The denominator consists of patients or short-stay residents 180 days of age or older on the target date of assessment who were in the facility/hospital for at least one day during the most recently-completed influenza vaccination season (IVS). The measure is based on data from the Minimum Data Set (MDS)</p>	<p>hypersensitivity to eggs or other components of the vaccine, see http://www.cdc.gov/flu/professionals/vaccination/vax-summary.htm) (NQF #0681c).</p> <p>The denominator consists of long-stay residents 180 days of age or older on the target date of assessment who were in the facility for at least one day during the most recently-completed influenza vaccination season (IVS). This measure is based on data from the Minimum Data Set (MDS 3.0) OBRA, PPS, and/or discharge assessments during the selected influenza season. Long-stay residents are identified as those who have had 101 or more cumulative days of nursing facility care.</p> <p>A separate measure (NQF #0680, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)) is to be used for residents who have had 100 or fewer cumulative days of nursing facility care.</p>		

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					<p>assessments of nursing home residents, Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) assessments for Inpatient Rehabilitation Facility (IRF) patients, and the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set Version assessments of LTCH patients.</p> <p>Data are collected in each of these three settings using standardized items across the three assessment instruments. For the nursing homes, the measure is limited to short-stay residents, identified as residents who have had 100 or fewer days of nursing home care. For the LTCHs, this measure will include all patients, irrespective of a patient's length of stay. For IRFs, this measure includes all Medicare Part A and Part C patients, irrespective of a patient's length of stay.</p>			
Type	Process	Process	Process	Process	Process	Process	Process	Process
Data Source	<p>Patient Reported Data/Survey This survey can be administered by mail, telephone, or internet. It is offered in English and Spanish. Organizations may use their own translation of the survey with approval of NCQA.</p> <p>Available at measure-specific web page URL identified in S.1 No data dictionary</p>	<p>Electronic Clinical Data, Electronic Clinical Data : Registry Not applicable No data collection instrument provided No data dictionary</p>	<p>Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records The necessary data elements are to be collected via the CMS CROWNWeb data repository.</p> <p>No data collection instrument provided No data dictionary</p>	<p>Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Management Data, Paper Medical Records, Patient Reported Data/Survey Data sources for required data elements include management/personnel data, medical or occupational health records, vaccination record documents, HCP self-reporting in writing (paper or electronic) that vaccination was received elsewhere, HCP providing</p>	<p>Electronic Clinical Data Nursing Home Minimum Data Set 3.0, Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), LTCH Continuity Assessment Record & Evaluation (Care) Data Set</p> <p>Available at measure-specific web page URL identified in S.1 No data dictionary</p>	<p>Electronic Clinical Data Nursing Home Minimum Data Set 3.0</p> <p>Available at measure-specific web page URL identified in S.1 No data dictionary</p>	<p>Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Medical Records An electronic data collection tool is made available from vendors or facilities can download the free CMS Abstraction & Reporting Tool (CART). Paper tools for manual abstraction, which are posted on www.QualityNet.org, are also available for the CART tool. These tools are posted on www.QualityNet.org.</p>	<p>Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Not applicable</p> <p>No data collection instrument provided Attachment CMS147v6_Preventive-Influenza_PCPI_valuesets_ APRIL2016.xlsx</p>

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				documentation of receipt of vaccine elsewhere, verbal or written declination by HCP, and verbal or written documentation of medical contraindications. Available at measure-specific web page URL identified in S.1 Attachment HCP Flu Data Dictionary-635049906022226964.doc x			Available at measure-specific web page URL identified in S.1 Attachment Appendix_A.Table_12.10_Organ_Transplant_ICD-10_ICD-9_codes.xls	
Level	Health Plan, Integrated Delivery System	Clinician : Group/Practice, Clinician : Individual	Facility	Facility	Facility	Facility	Facility	Clinician : Group/Practice, Clinician : Individual
Setting	Ambulatory Care : Clinician Office/Clinic, Home Health, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Pharmacy, Ambulatory Care : Urgent Care	Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Other Domiciliary	Dialysis Facility	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Hospital/Acute Care Facility	Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Other Domiciliary
Numerator Statement	This measure is reported as two rates: Flu Vaccination for Adults age 18-64 – Respondents to the Medicaid or commercial CAHPS survey who report having received an influenza vaccination since July of the previous year. Flu Vaccination for Adults age 65+ - Respondents to the Medicare CAHPS survey who report having received an influenza vaccination since July of the previous year.	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization	Number of patients from the denominator who: 1. received an influenza vaccination,* documented by the provider or reported receipt from another provider by the patient (computed and reported separately); OR 2. were assessed and offered an influenza vaccination but declined (computed and reported separately); OR	HCP in the denominator population who during the time from October 1 (or when the vaccine became available) through March 31 of the following year: (a) received an influenza vaccination administered at the healthcare facility, or reported in writing (paper or electronic) or provided documentation that influenza vaccination was received elsewhere; or (b) were determined to have a medical contraindication/condition	The numerator for the overall measure (NQF #0680) is the number of residents or patients in the denominator sample who, during the numerator time window, meet any one of the following criteria: (1) those who received the seasonal influenza vaccine during the most recently-completed influenza season, either in the facility/hospital or outside the facility/hospital (NQF #0681a); (2) those who were offered and declined	The numerator is the number of long-stay residents with a target assessment (OBRA admission, quarterly, annual or significant change/correction assessments; PPS 5-,14-, 30-, 60-, 90-day, or readmission/return assessments; or discharge assessment with or without return anticipated) who were in the denominator sample, AND who meet any of the following criteria for the	Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated.	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

	0039 Flu Vaccinations for Adults Ages 18 and Older	0041 Preventive Care and Screening: Influenza Immunization	0226 Influenza Immunization in the ESRD Population (Facility Level)	0431 Influenza Vaccination Coverage Among Healthcare Personnel	0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)	0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)	1659 Influenza Immunization	3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)
			<p>3. were assessed and determined to have a medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, and/or bone marrow transplant within the past 6 months (<6 months prior to encounters between October 1 and March 31) (computed and reported separately).</p> <p>*Only inactivated vaccine should be used in the ESRD population.</p>	<p>of severe allergic reaction to eggs or to other component(s) of the vaccine, or history of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination; or</p> <p>(c) declined influenza vaccination; or</p> <p>(d) persons with unknown vaccination status or who do not otherwise meet any of the definitions of the above-mentioned numerator categories. Numerators are to be calculated separately for each of the above groups.</p>	<p>the seasonal influenza vaccine (NQF #0681b); or</p> <p>(3) those who were ineligible due to contraindication(s) (NQF #0681c). The numerator time window coincides with the most recently-completed seasonal IVS which begins on October 1 and ends on March 31 of the following year.</p> <p>Each of the three submeasures numerators described above will be computed and reported separately, alongside the overall numerator calculated as the aggregate of the three submeasure numerators.</p>	<p>selected influenza season: (1) they received the influenza vaccine during the most recent influenza season, either in the facility or outside the facility (NQF #0681a), (2) they were offered and declined the influenza vaccine (NQF #0681b), or (3) they were ineligible due to medical contraindication(s) (NQF #0681c) . The influenza season is defined as July 1 of the current year to June 30 of the following year. The IVS begins on October 1 and ends on March 31 of the following year.</p> <p>Each of the three submeasure numerators described above will be computed and reported separately, alongside the overall numerator calculated as the aggregate of the three submeasure numerators.</p>		
Numerator Details	<p>Flu Vaccinations for Adults Ages 18-64 – CAHPS respondents answering “yes” to the question: “Have you had either a flu shot or flu spray in the nose since July 1, YYYY?” where YYYY is the measurement year (e.g. 2014 for the survey fielded in 2015). Response Choices: “Yes, No, Don’t know”</p> <p>Flu Vaccination for Adults Age 65 and Older – CAHPS respondents answering “yes” to the question: “Have you had a flu shot or flu spray since July 1, YYYY?” where YYYY is the measurement year (e.g. 2014 for the survey fielded in 2015). Response</p>	<p>For Registry: NUMERATOR DEFINITION: Previous Receipt – Receipt of the current season’s influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st). NUMERATOR GUIDANCE: The numerator for this measure can be met by reporting either administration of an influenza vaccination or that the patient reported previous receipt of the current season’s influenza</p>	<p>Include in the numerator all patients from the denominator who:*</p> <ol style="list-style-type: none"> 1. Received an influenza vaccination** (documented by the provider or reported receipt from another provider by the patient). 2. Were assessed and offered an influenza vaccination but declined. 3. Were assessed and were determined to have a medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, 	<ol style="list-style-type: none"> 1. Persons who declined vaccination because of conditions other than those specified in the 2nd numerator category above should be categorized as declined vaccination. 2. Persons who declined vaccination and did not provide any other information should be categorized as declined vaccination. 3. Persons who did not receive vaccination because of religious or philosophical exemptions should be categorized as declined vaccination. 4. Persons who deferred vaccination all season 	<p>The numerator for the overall measure (NQF #0680) includes all patients or short-stay residents in the denominator sample who, during the numerator time window, meet one of three criteria: (1) received the seasonal influenza vaccine during the most recent influenza season, either inside or outside the facility/hospital, (2) were offered and declined the vaccine, or (3) were ineligible due to medical contraindications.</p> <p>For each setting (i.e., nursing homes, inpatient rehabilitation facilities, and long-term care hospitals), the numerator components are also</p>	<p>Residents are counted if they are long-stay residents, defined as residents who have had 101 or more cumulative days of nursing facility care, are 180 days of age and older and who were in a nursing facility for at least one day during the most recently completed IVS. Residents who return to the nursing home following a hospital discharge will not have their stay reset to zero. The numerator is the number of long-stay residents in the denominator sample with a selected target assessment (OBRA admission, quarterly,</p>	<p>The following are included in the numerator:</p> <ul style="list-style-type: none"> • Patients who received the influenza vaccine during this inpatient hospitalization • Patients who received the influenza vaccine during the current year’s flu season but prior to the current hospitalization • Patients who were offered and declined the influenza vaccine • Patients who have an allergy/sensitivity to the influenza vaccine, anaphylactic latex allergy or anaphylactic allergy to eggs, or for whom the vaccine is not likely to be 	<p>For EHR: Health Quality Measures Format (HQMF) eMeasure developed and is attached to this submission in field S.2a. We have provided the following definitions and/or guidance for convenience; please see HQMF eMeasure for complete details related to the specification. NUMERATOR DEFINITION: Previous Receipt - receipt of the current season’s influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination</p>

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	Choices: "Yes, No, Don't know"	<p>immunization. If the performance of the numerator is not met, an eligible clinician can report a valid Denominator Exception for having not administered an influenza vaccination.</p> <p>NUMERATOR SPECIFICATION: Report one of the following options:</p> <p>CPT Code for Influenza Immunization: •90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90664,90666, 90667, 90668, 90672, 90673, 90685, 90686, 90687, 90688</p> <p>OR</p> <p>Quality data code for Influenza Immunization or Prior Receipt: •G8482: Influenza immunization administered or previously received</p>	<p>and/or bone marrow transplant within the past 6 months (<6 months prior to encounters between October 1 and March 31).</p> <p>*Each of the 3 numerator subcategories are to be computed and reported separately.</p> <p>**Only inactivated vaccine should be used in the ESRD population.</p>	<p>should be categorized as declined vaccination.</p> <p>5. The numerator categories are mutually exclusive. The sum of the four numerator categories should be equal to the denominator.</p>	<p>computed and reportedly separately as a submeasure.</p> <p>Specifications for the three provider type assessment tools are listed below: MDS: Residents are counted if they are short-stay residents, defined as residents whose length of stay is less than or equal to 100 days. Short-stay residents are included in the numerator for the overall measure (NQF #0680) if they meet any of the following criteria during the numerator time window: (1) received the influenza vaccine during the most recent influenza vaccine season, either in the facility (O0250A=1) or outside the facility (O0250C=2) (also computed and reportedly separately as a submeasure); or (2) offered and declined the influenza vaccine (O0250C=4) (also computed and reportedly separately as a submeasure); or (3) ineligible due to medical contraindication(s) (O0250C=3) (also computed and reportedly separately as a submeasure). Included in the numerator are short-stay residents who meet the criteria on the selected MDS assessment. The record selected will be the record with the latest target date that meets all of the following conditions: (1) it has a qualifying reason for assessment (OBRA (A0310A=01,02,03,04,05,0</p>	<p>annual or significant change/correction assessments; PPS 5-, 14-, 30-, 60-, 90-day, or readmission/return assessments; or discharge assessment with or without return anticipated) during the most recently selected influenza season who meet any of the following criteria: (1) Resident received the influenza vaccine during the most recent influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]) (NQF #0681a, computed separately); or (2) Resident was offered and declined the influenza vaccine (O0250C = [4]) (NQF #0681b, computed separately); or (3) Resident was ineligible due to contraindication(s) (O0250C = [3]) (NQF #0681c, computed separately) (e.g., anaphylactic hypersensitivity to eggs or other components of the vaccine).</p>	<p>effective because of bone marrow transplant within the past 6 months, or history of Guillian-Barre Syndrome within 6 weeks after a previous influenza vaccination</p> <p>Data Elements required for the numerator:</p> <ul style="list-style-type: none"> • ICD-10-CM Other Diagnosis Codes • ICD-10-PCS Other Procedure Codes • ICD-10-CM Principal Diagnosis Code • ICD-10-PCS Principal Procedure Code • Influenza Vaccination Status 	<p>would include influenza vaccine given since August 1st)</p>

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					<p>6), PPS (A0310B=01,02,03,04,05,06) or discharge assessment (A0310F=10, 11), (2) the target date is on or after October 1st of the most recently completed influenza season, and (3) the entry date is on or before March 31st of the most recently completed influenza season.</p> <p>IRF-PAI: Patients are included in the numerator for the overall measure (NQF #0680) for stays that meet any of the following criteria during the numerator time window: (1) received the influenza vaccine during the most recently-completed influenza season, either in the facility (O0250A = 1) or outside the facility (O0250C = 2) ; or (2) offered and declined the influenza vaccine (O0250C = 4; or (3) ineligible due to medical contraindication(s) (O0250C = 3). All three of these also computed and reported separately as submeasures. Included in the numerator are patients who meet the criteria based on data reported on the IRF-PAI assessments during the denominator time window. Note: IRF-PAI assessments are submitted to CMS for Medicare Part A and Part C patients.</p> <p>LTCH CARE Data Set (LCDS): Patients are included in the numerator for the overall measure (NQF #0680) for patient stays that meet any of the following criteria during the numerator time</p>			

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					<p>window: (1) received the influenza vaccine during the most recent influenza season, either in the facility (O250A=1) or outside the facility (O0250C=2) ; or (2) offered and declined the influenza vaccine (O0250C=4); or (3) ineligible due to medical contraindication(s) (O0250C=3).All three of these also computed and reportedly separately as submeasures. Included in the numerator are patients who meet the criteria on the LTCH CARE Data Set admission assessment (A0250=01), discharge or expired patient assessment (A0250=10, 11, 12) during the denominator time window. Note: LCDS expired assessments (A0250=12) completed before April 1, 2016 are not included in the numerator because prior to this date the influenza items were not included on expired assessments.</p>			
Denominator Statement	<p>Flu Vaccinations for Adults Ages 18-64 – Medicaid and Commercial CAHPS respondents age 18-64 Flu Vaccination for Adults Age 65 and Older – Medicare CAHPS respondents age 65 and older.</p>	<p>All patients aged 6 months and older seen for a visit between October 1 and March 31</p>	<p>All ESRD patients aged 6 months and older receiving hemodialysis and/or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31.</p>	<p>Number of HCP who are working in the healthcare facility for at least 1 working day between October 1 and March 31 of the following year, regardless of clinical responsibility or patient contact. Denominators are to be calculated separately for: (a) Employees: all persons who receive a direct paycheck from the reporting facility (i.e., on the facility's payroll). (b) Licensed independent practitioners: include physicians (MD, DO), advanced practice nurses,</p>	<p>The denominator consists of patients or short-stay residents 180 days of age and older on the target date of the assessment who were in the facility/hospital for at least one day during the denominator time window. The denominator time window is defined as the most recently-completed IVS, from October 1 to March 31 of the following year. For IRF and LTCH, the QM is based on completed patient stays (have discharge assessments). An IRF or LTCH patient with multiple stays during the</p>	<p>The denominator is the total number of long-stay residents 180 days of age or older on the target date of the assessment who were in the nursing facility who were in a nursing facility for at least one day during the most recently completed IVS that have an OBRA, PPS, or discharge assessment and who did not meet the exclusion criteria.</p>	<p>Acute care hospitalized inpatients age 6 months and older discharged during the months of October, November, December, January, February or March.</p>	<p>All patients aged 6 months and older seen for a visit between October 1 and March 31</p>

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				and physician assistants only who are affiliated with the reporting facility who do not receive a direct paycheck from the reporting facility. (c) Adult students/trainees and volunteers: include all students/trainees and volunteers aged 18 or over who do not receive a direct paycheck from the reporting facility.	denominator time window (IVS) will be included more than once in the QM. If a nursing home resident has more than one episode during the denominator time window only the more recent episode is included in this QM.			
Denominator Details	Flu Vaccination for Adults Ages 18-64 - The number of patients age 18-64 who responded "Yes" or "No" to the question "Have you had either a flu shot or flu spray in the nose since July 1, YYYY?" Flu Vaccination for Adults Age 65 and Older – The number of patients age 65 and older who responded "Yes" or "No" to the question, "Have you had a flu shot or flu spray in the nose since July 1, YYYY?"	For Registry: DENOMINATOR SPECIFICATION: Age >= 6 months AND At least one encounter during measurement period (CPT or HCPCS): 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, 99512, G0438, G0439	Include in the denominator all patients within a facility who meet the following criteria during the time from October 1 (or when the influenza vaccine became available) to March 31 of the reporting year: 1. Diagnosis = ESRD AND 2. Primary type of dialysis = hemodialysis, home hemodialysis, continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), or nighttime intermittent peritoneal dialysis (NIPD). AND 3. Age = >=6 months	1. Include all HCP in each of the denominator categories who have worked at the facility between October 1 and March 31 for at least 1 working day. This includes persons who joined after October 1 or who left before March 31, or who were on extended leave during part of the reporting period. Working for any number of hours in a day should be counted as a working day. 2. Include both full-time and part-time personnel. If a person works in two or more facilities, each facility should include the person in their denominator. 3. Count persons as individuals rather than full-time equivalents. 4. Licensed practitioners who receive a direct paycheck from the reporting facility, or who are owners of the reporting facility, should be counted as employees. 5. The denominator categories are mutually exclusive. The numerator data are to be reported separately for each of the denominator categories.	The denominator time window is defined as the most recently-completed IVS, from October 1 to March 31 of the following year. Measure specifications for the three assessment tools are listed below. For IRF and LTCH, the QM is based on stays with admission and discharge assessments. An IRF or LTCH patient with multiple stays during the denominator time window (IVS) will be included more than once in the QM. If a nursing home resident has more than one episode during the denominator time window only the more recent episode is included in this QM. MDS (in use in Nursing Homes/Skilled Nursing Facilities): Residents are counted if they are short-stay residents, defined as residents whose length of stay is less than or equal to 100 days. The sample includes residents, aged 180 days or older, meeting the following conditions: the resident has an OBRA assessment (A0310A=01,02,03,04,05,06) or PPS assessment (A0310B=01,02,03,04,05,0	Residents are counted if they are long-stay residents, defined as residents who have had 101 or more cumulative days of nursing facility care. Residents who return to the nursing home following a hospital discharge will not have their length of stay reset to zero. The target population includes all long-stay residents with a target assessment (assessments may be OBRA admission, quarterly, annual or significant change/correction assessments (A0310A = 01, 02, 03, 04, 05, 06) or PPS 5-, 14-, 30-, 60-, 90-day, or readmission/return assessments (A0310B = 01, 02, 03, 04, 05, 06) or discharge assessment with or without return anticipated (A0310F = 10, 11) who were in a nursing facility for at least one day during the most recently completed IVS, except for those who meet the exclusion criteria (specified in S.10 and S.11).	Data Elements required for the denominator: <ul style="list-style-type: none"> Admission Date Birthdate Discharge Date Discharge Disposition ICD-10-PCS Other Procedure Codes ICD-10-PCS Principal Procedure Code 	For EHR: HQMF eMeasure developed and is attached to this submission in field S.2a. We have provided the following definitions and/or guidance for convenience; please see HQMF eMeasure for complete details related to the specification. DENOMINATOR GUIDANCE: The timeframe for the visit during the "Encounter, Performed: Encounter-Influenza" or "Procedure, Performed: Peritoneal Dialysis" or "Procedure, Performed: Hemodialysis" in the Population Criteria-Denominator, refers to the influenza season defined by the measure: October through March (October 1 for the year prior to the start of the reporting period through March 31 during the reporting period). The "Encounter-Influenza" Grouping OID detailed in the data criteria section below is comprised of several individual OIDs of different encounter types. The individual OIDs are included in the value

	0039 Flu Vaccinations for Adults Ages 18 and Older	0041 Preventive Care and Screening: Influenza Immunization	0226 Influenza Immunization in the ESRD Population (Facility Level)	0431 Influenza Vaccination Coverage Among Healthcare Personnel	0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)	0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)	1659 Influenza Immunization	3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)
					<p>6) or discharge assessment (A0310F=10, 11) with an assessment reference date on or after the start of the denominator time window and an entry date (A1600) on or before the end of the denominator time window.</p> <p>IRF-PAI (in use in Inpatient Rehabilitation Facilities): Patient stays are included in the sample if patients are 180 days or older and have a stay that includes 1 or more days in the IRF during the denominator time window (the IVS). Patient stays must meet any of the following conditions: (1) the patient has an admission assessment with an entry date (item 12) during the denominator time window; (2) the patient has a discharge assessment with a discharge date (Item 40) during the denominator time window; or (3) the patient has an admission with an entry date (item 12) before the denominator time window and a discharge date (item 40) after the denominator time window.</p> <p>LTCH CARE Data Set (in use in Long-Term Care Hospitals): Patient stays are included in the sample if patients are 180 days of age or older at discharge and have a stay that includes 1 or more days in the LTCH during the denominator time window. Stays must meet either of the following conditions: (1) a stay with an admission date (A0220) or a planned or unplanned (A0250 = 10, 11) discharge</p>			<p>set and should be reviewed to determine that an applicable visit occurred during the timeframe for "Encounter, Performed: Encounter-Influenza" as specified in the denominator.</p> <p>To enable reporting of this measure at the close of the reporting period, this measure will only assess the influenza season that ends in March of the reporting period. The subsequent influenza season (ending March of the following year) will be measured and reported in the following year.</p> <p>To account for the majority of reporting years' appropriate flu season duration, the measure logic will look at the first 89 days of the measurement period for the appropriate criteria and actions to be present/performed (January 1 through March 31). The measure developer believes it is best to keep the logic as static as possible from one reporting year to the next. Therefore, during leap years, only encounters that occur through March 30 will be counted in the denominator.</p>

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					date (A0270) or an expired patient assessment (A0250 = 12) within the denominator time window; or (2) a stay with the admission date (A0220) before the denominator time window and a planned or unplanned discharge (A0250 = 10, 11) with discharge or date (A0270) or a patient expired assessment (A0250 = 12) with date of death (A0270) after the denominator time window.			
Exclusions	N/A	Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons) Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons) Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons)	None.	None.	Residents or patients whose age is 179 days or less of age on target date of the selected influenza vaccination assessment are excluded. LTCH patients whose expired assessments are completed before April 1, 2016 are excluded. After April 1, 2016 expired patients are no longer excluded from the QM, because the influenza items were added to the LCDS expired assessments. Nursing homes with denominator counts of less than 20 residents and IRFs and LTCHs with less than 20 stays in the sample are excluded from public reporting due to small sample size.	Residents whose age is 179 days or less on target date of selected influenza vaccination assessment are excluded. If the facility sample includes fewer than 30 residents after all other resident-level exclusions are applied, then the facility is excluded from public reporting.	The following patients are excluded from the denominator: <ul style="list-style-type: none"> Patients less than 6 months of age Patients who expire prior to hospital discharge Patients with an organ transplant during the current hospitalization (Appendix_A.Table 12.10 Organ Transplant codes.xls) Patients for whom vaccination was indicated, but supply had not been received by the hospital due to problems with vaccine production or distribution Patients who have a Length of Stay greater than 120 days Patients who are transferred or discharged to another acute care hospital Patients who leave Against Medical Advice (AMA) 	Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons) Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons) Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons)
Exclusion Details	N/A	Exceptions are used to remove a patient from the denominator of a performance measure	Not applicable.	Not applicable.	Residents or patients with age 179 days or less are excluded, with age calculation based on the	Residents whose age is 179 days or less are excluded, with age calculation based on the resident birthdate	To determine the length of stay, the admission date and discharge date are entered. If the result of the	Exceptions are used to remove a patient from the denominator of a performance measure

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		<p>when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure on Preventive Care and Screening: Influenza Immunization, exceptions may include medical reason(s) (eg, patient allergy); patient reason(s) (eg, patient declined); or system reason(s) for the patient not receiving influenza immunization (eg, vaccine not available). Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that</p>			<p>resident and patient birthdate and the target date of the selected influenza vaccination assessment.</p>	<p>and the target date of the selected influenza vaccination assessment.</p>	<p>calculation subtracting the admission date from the discharge date is greater than 120 days the patient is excluded from the measure. The patient's date of birth is entered. If the calculation result of the admission date minus the birth date is less than 6 months the patient is excluded from the measure. Patients who had an organ transplant during the current hospitalization are excluded based on having an ICD-10 PCS Principal or Other Procedure Code assigned as having occurred during the current hospitalization. If the patient has at least one code from the list on Appendix_A.Table 12.10 Organ Transplant codes.xls assigned for the current hospitalization they are excluded. Discharge Disposition is a manually abstracted data element. If documentation in the patient's medical record is consistent with the criteria specified in the Discharge Disposition data element for discharge to an acute care facility, patient expired prior to hospital discharge, or the patient left against medical advice the patient is excluded from the measure. The Influenza Vaccination Status is a manually abstracted data element for the measure. Allowable Value 6 may be selected if there is documentation in the medical record</p>	<p>when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure on Preventive Care and Screening: Influenza Immunization, exceptions may include medical reason(s) (eg, patient allergy); patient reason(s) (eg, patient declined); or system reason(s) for the patient not receiving influenza immunization (eg, vaccine not available). Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that</p>

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		<p>physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.</p> <p>Additional details by data source are as follows: For Registry: DENOMINATOR EXCEPTION GUIDANCE: For eligible clinicians reporting a Denominator Exception for this measure, there should be a clear rationale and documented reason for not administering an influenza immunization if the patient did not indicate previous receipt, which could include a medical reason (eg, patient allergy, other medical reason), patient reason (eg, patient declined, other patient reason), or system reason (eg, vaccination not available, other system reason). The system reason should be indicated only for cases of disruption or shortage of influenza vaccination supply. DENOMINATOR EXCEPTION SPECIFICATION: To report a denominator exception, report the following quality data code: G8483: Influenza immunization was not</p>					<p>reflecting the hospital has ordered the influenza vaccine but has not yet received it based on problems with vaccine production or distribution. If this value is selected the measure algorithm will exclude the patient from the measure.</p>	<p>physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.</p> <p>Additional details by data source are as follows: For EHR: HQMF eMeasure developed and is attached to this submission in field S.2a.</p>

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		administered for reasons documented by clinician (eg, patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons)						
Risk Adjustment	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification No risk adjustment or risk stratification.	No risk adjustment or risk stratification Not applicable.	No risk adjustment or risk stratification Not applicable. Provided in response box S.15a	No risk adjustment or risk stratification This section is not applicable. Provided in response box S.15a	No risk adjustment or risk stratification This is not applicable. Provided in response box S.15a	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification No risk adjustment or risk stratification
Stratification	N/A	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.	Not applicable.	The measure should be calculated separately for each denominator group of healthcare personnel: employees; licensed independent practitioners; and adult students/trainees and volunteers. Definitions for these groups are as follows: (a) Employees: all persons who receive a direct paycheck from the reporting facility (i.e., on the facility's payroll). (b) Licensed independent practitioners: physicians (MD, DO), advanced practice nurses, and physician assistants who are affiliated with the reporting facility, but are not directly employed by it (i.e., they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact. Post-residency fellows are also included in this category if they are not on the facility's payroll. (c) Adult students/trainees and volunteers: medical, nursing, or other health professional students, interns, medical residents,	This section is not applicable.	This is not applicable.	Measure is not stratified.	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

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				or volunteers aged 18 or older who are affiliated with the healthcare facility, but are not directly employed by it (i.e., they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact.				
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	<p>Flu Vaccination for Adults Ages 18-64</p> <p>Step 1) Identify the eligible population of Medicaid and Commercial CAHPS respondents</p> <p>Step 2) Identify the denominator: Adults age 18-64 as of July 1 of the measurement year who responded “yes” or “no” to the question “Have you had either a flu shot or flu spray in the nose since July 1, YYYY?” Respondents who answer “don’t know” or have a missing response are not included in the denominator.</p> <p>Step 3) Identify the numerator: Adults in the denominator who answer “yes” to the question.</p> <p>Step 4) Calculate the rate as numerator/denominator</p> <p>Flu Vaccination for Adults Age 65 and Older</p> <p>Step 1) Identify the eligible population of Medicare CAHPS respondents</p> <p>Step 2) Identify the denominator: Adults age 65 as of July 1 of the measurement year who responded “yes” or “no” to the question “Have you had a flu shot or flu spray in the nose since July 1,</p>	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> 1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator. 4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria 	<p>DENOMINATOR</p> <p>Include in the denominator all patients within a facility who meet the following criteria during the time from October 1 (or when the influenza vaccine became available) to March 31 of the reporting year:</p> <ol style="list-style-type: none"> 1. Diagnosis = ESRD AND 2. Primary type of dialysis = hemodialysis, home hemodialysis, continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), or nighttime intermittent peritoneal dialysis (NIPD) AND 3. Age = >=6 months or older as of the first day of the most recent month of the reporting period. (Patient’s age is or shall be determined by subtracting the patient’s date of birth from the first day of the most recent month of the reporting period.) <p>NUMERATOR</p> <p>Include in the numerator all patients from the denominator who meet the following criteria:**</p>	<p>Among each of the denominator groups, the measure may be calculated by dividing the number of HCP in the first numerator category (i.e., received an influenza vaccination) by the number of HCP in that denominator group, and multiplying by 100 to produce a vaccination rate expressed as a percentage of all HCP in the denominator group. Rates of medical contraindications, declinations, and unknown vaccination status can be calculated similarly using the second, third, and fourth numerator categories, respectively.</p> <p>As noted above, numerator categories should not be summed; each numerator status should be calculated and reported separately. Available at measure-specific web page URL identified in S.1</p>	<p>For each setting the calculation algorithm for the overall measure and submeasures a-c are:</p> <p>Step 1: Identify the total number of residents or patients meeting the denominator criteria.</p> <p>Step 2: For the first submeasure (NQF #0680a: Percent of Residents or Patients Who Received the Seasonal Influenza Vaccine (short stay)):</p> <p>Step 2a: Identify the total number of patients or short-stay residents who received the seasonal influenza vaccine during the current or most recently completed influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]).</p> <p>Step 2b: Divide the results of Step 2a by the result of Step 1.</p> <p>Step 3: For the second submeasure (NQF #0680b: Percent of Residents or Patients Who Offered and Declined the Seasonal Influenza Vaccine (short stay)):</p> <p>Step 3a: Identify the total number of patients or short-stay residents who were offered and declined</p>	<p>The calculation algorithm for the overall measure and submeasures a-c are:</p> <p>Step 1: Identify the total number of residents meeting the denominator criteria.</p> <p>For the first submeasure (NQF #0681a: Percent of Residents Who Received the Seasonal Influenza Vaccine (long stay)):</p> <p>Step 2a: Identify the total number of long-stay residents who received the seasonal influenza vaccine during the current or most recently completed influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]).</p> <p>Step 3a: Divide the results of Step 2a by the result of Step 1.</p> <p>For the second submeasure (NQF #0681b: Percent of Residents Who Offered and Declined the Seasonal Influenza Vaccine (long stay)):</p> <p>Step 2b: Identify the total number of long-stay residents who were offered and declined the seasonal influenza vaccine (O0250C = [4]).</p>	<p>Numerator: Inpatient discharges who were screened for Influenza vaccine status and were vaccinated prior to discharge if indicated.</p> <p>Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October, November, December, January, February or March.</p> <p>Variable Key: Patient Age</p> <ol style="list-style-type: none"> 1. Start processing. Run cases that are included in the Global Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure. 2. Calculate Patient Age. Patient Age, in years, is equal to the Admission Date minus the Birthdate. Use the month and day portion of admission date and birthdate to yield the most accurate age. Only cases with valid Admission Date and Birthdate will pass the critical feedback messages into the measure specific algorithms. 3. Check Patient Age <ol style="list-style-type: none"> a. If the Patient Age is less than 6 months old, the case will proceed to a 	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> 1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria

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	<p>YYYY?" Respondents who answer "don't know" or have a missing response are not included in the denominator.</p> <p>Step 3) Identify the numerator: Adults in the denominator who answer "yes" to the question.</p> <p>Step 4) Calculate the rate as numerator/denominator</p> <p>No diagram provided</p>	<p>for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, patient allergy) patient reason(s) (eg, patient declined) or system reason(s) for the patient not receiving influenza immunization (eg, vaccine not available, other system reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. No diagram provided</p>	<ol style="list-style-type: none"> 1. Patient received an influenza vaccination* (documented by the provider or reported receipt from another provider by the patient); OR 2. Patient was assessed and offered an influenza vaccination but declined; OR 3. Patient was assessed and was determined to have a medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, and/or bone marrow transplant within the past 6 months (<6 months prior to encounters between October 1 and March 31). <p>*Only inactivated vaccine should be used in the ESRD population.</p> <p>** Each of the 3 numerator subcategories are to be computed and reported separately. No diagram provided</p>		<p>the seasonal influenza vaccine (O0250C = [4]).</p> <p>Step 3b: Divide the results of Step 3a by the result of Step 1.</p> <p>Step 4: For the third submeasure (NQF #0680c: Percent of Residents or Patients Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine (short stay)):</p> <p>Step 4a: Identify the total number of patients or short-stay residents who were ineligible due to medical contraindication(s) (O0250C = [3]).</p> <p>Step 4b: Divide the results of Step 4a by the result of Step 1.</p> <p>Step 5: For the overall measure (NQF #0680: Percent of Residents or Patients Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)):</p> <p>Step 5a: Aggregate Step 2a, 3a, and 4a [Sum the total number of short-stay residents or patients who met any one of the following criteria: who received the seasonal influenza vaccine during the current or most recently completed influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]); OR who were offered and declined the seasonal influenza vaccine (O0250C = [4]); OR who were ineligible due to medical contraindication(s) (O0250C = [3]).]</p> <p>Step 5b: Divide the results of Step 5a by the result of</p>	<p>Step 3b: Divide the results of Step 2b by the result of Step 1.</p> <p>For the third submeasure (NQF #0681c: Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine (long stay)):</p> <p>Step 2c: Identify the total number of long-stay residents who were ineligible due to medical contraindication(s) (O0250C = [3]).</p> <p>Step 3c: Divide the results of Step 2c by the result of Step 1.</p> <p>For the overall measure (NQF #0681: Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)):</p> <p>Step 2d: Aggregate Step 2a, 2b, and 2c [Sum the total number of long-stay residents who met any of the following criteria: who received the seasonal influenza vaccine during the current or most recently completed influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]); OR who were offered and declined the seasonal influenza vaccine (O0250C = [4]); OR who were ineligible due to medical contraindication(s) (O0250C = [3]).]</p> <p>Step 3d: Divide the results of Step 2d by the result of Step 1. Available at measure-specific web page URL identified in S.1</p>	<p>Measure Category Assignment of B and will not be in the Measure Population. Stop processing.</p> <p>b. If the Patient Age is greater than or equal to 6 months, continue processing and proceed to ICD-10-PCS Principal or Other Procedure Codes.</p> <p>4. Check ICD-10-PCS Principal or Other Procedure Codes</p> <p>a. If at least one of ICD-10-PCS Principal or Other Procedure Codes is on Appendix_A.Table 12.10 Organ Transplant codes.xls the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.</p> <p>b. If all of ICD-10-PCS Principal or Other Procedure Codes are missing or none of ICD-10-PCS Principal or Other Procedure Codes is on Appendix_A.Table 12.10 Organ Transplant codes.xls, continue processing and check Discharge Disposition.</p> <p>5. Check Discharge Disposition</p> <p>a. If Discharge Disposition equals 4, 6, or 7 the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.</p> <p>b. If Discharge Disposition equals 1, 2, 3, 5, or 8 continue processing and proceed to Discharge Date.</p>	<p>for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, patient allergy) patient reason(s) (eg, patient declined) or system reason(s) for the patient not receiving influenza immunization (eg, vaccine not available, other system reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.</p> <p>If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. No diagram provided</p>

	0039 Flu Vaccinations for Adults Ages 18 and Older	0041 Preventive Care and Screening: Influenza Immunization	0226 Influenza Immunization in the ESRD Population (Facility Level)	0431 Influenza Vaccination Coverage Among Healthcare Personnel	0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)	0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)	1659 Influenza Immunization	3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)
					Step 1. Available at measure-specific web page URL identified in S.1		<p>c. If Discharge Disposition is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.</p> <p>6. Check Discharge Date. Note: 'yyyy' refers to the specific year of discharge.</p> <p>a. If the Discharge Date is 04-01-yyyy through 09-30-yyyy, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.</p> <p>b. If the Discharge Date is 10-01-yyyy through 03-31-yyyy, continue processing and proceed to Influenza Vaccination Status.</p> <p>7. Check Influenza Vaccination Status</p> <p>a. If Influenza Vaccination Status is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.</p> <p>b. If Influenza Vaccination Status equals 6, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.</p> <p>c. If Influenza Vaccination Status equals 1, 2, 3, 4, or 5, continue processing and recheck Influenza Vaccination Status.</p> <p>8. Recheck Influenza Vaccination Status</p>	

	0039 Flu Vaccinations for Adults Ages 18 and Older	0041 Preventive Care and Screening: Influenza Immunization	0226 Influenza Immunization in the ESRD Population (Facility Level)	0431 Influenza Vaccination Coverage Among Healthcare Personnel	0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)	0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)	1659 Influenza Immunization	3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)
							<p>a. If Influenza Vaccination Status equals 5, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.</p> <p>b. If Influenza Vaccination Status equals 1, 2, 3, or 4 the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing. Available at measure-specific web page URL identified in S.1</p>	
Submission items	<p>5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)</p> <p>0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)</p> <p>0226 : Influenza Immunization in the ESRD Population (Facility Level)</p> <p>0227 : Influenza Immunization</p> <p>0041 : Preventive Care and Screening: Influenza Immunization</p> <p>0431 : Influenza Vaccination Coverage Among Healthcare Personnel</p> <p>0522 : Influenza Immunization Received for Current Flu Season (Home Health)</p> <p>1659 : Influenza Immunization</p> <p>5a.1 Are specs completely harmonized? No</p>	<p>5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)</p> <p>0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)</p> <p>0226 : Influenza Immunization in the ESRD Population (Facility Level)</p> <p>0039 : Flu Vaccinations for Adults Ages 18 and Older</p> <p>0431 : Influenza Vaccination Coverage Among Healthcare Personnel</p> <p>0522 : Influenza Immunization Received for Current Flu Season (Home Health)</p> <p>1659 : Influenza Immunization</p> <p>5a.1 Are specs completely harmonized? No</p> <p>5a.2 If not completely harmonized, identify difference, rationale,</p>	<p>5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)</p> <p>0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)</p> <p>0227 : Influenza Immunization</p> <p>0039 : Flu Vaccinations for Adults Ages 18 and Older</p> <p>0041 : Preventive Care and Screening: Influenza Immunization</p> <p>0149 : Influenza vaccination</p> <p>0432 : Influenza Vaccination of Nursing Home/ Skilled Nursing Facility Residents</p> <p>0522 : Influenza Immunization Received for Current Flu Season (Home Health)</p> <p>1659 : Influenza Immunization</p>	<p>5.1 Identified measures: 5a.1 Are specs completely harmonized? No</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact: An additional category was added to the numerator statement to explicitly capture "unknown" vaccination status. See Section 4d.1 for rationale.</p> <p>5b.1 If competing, why superior or rationale for additive value: Not applicable.</p>	<p>5.1 Identified measures: 0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)</p> <p>1659 : Influenza Immunization</p> <p>5a.1 Are specs completely harmonized? Yes</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value: The current measure for Nursing Homes is expanded to both additional post-acute care settings (LTCHs and IRFs), as well as to additional data sources (MDS 3.0 remained the data source of nursing homes, IRF-PAI is the data source for IRFs, and the LTCH CARE Data Set is the data source for LTCHs).The proposed measure is harmonized to the NQF Voluntary Consensus Standards for</p>	<p>5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)</p> <p>1659 : Influenza Immunization</p> <p>5a.1 Are specs completely harmonized? Yes</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value: NQF #0680 Percent of Residents or Patients Assessed and Appropriately Given the Seasonal Influenza Vaccine (SS) applies to short-stay nursing home residents as well as additional post-acute care settings (LTCHs and IRFs), and is based on different data sources for each setting (MDS 3.0 for nursing homes, IRF-PAI is the data source for IRFs, and the LTCH CARE Data</p>	<p>5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)</p> <p>0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)</p> <p>0226 : Influenza Immunization in the ESRD Population (Facility Level)</p> <p>0038 : Childhood Immunization Status (CIS)</p> <p>0039 : Flu Vaccinations for Adults Ages 18 and Older</p> <p>0041 : Preventive Care and Screening: Influenza Immunization</p> <p>0431 : Influenza Vaccination Coverage Among Healthcare Personnel</p> <p>0522 : Influenza Immunization Received for Current Flu Season (Home Health)</p> <p>5a.1 Are specs completely harmonized? No</p>	<p>5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)</p> <p>0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)</p> <p>0226 : Influenza Immunization in the ESRD Population (Facility Level)</p> <p>0039 : Flu Vaccinations for Adults Ages 18 and Older</p> <p>0431 : Influenza Vaccination Coverage Among Healthcare Personnel</p> <p>0522 : Influenza Immunization Received for Current Flu Season (Home Health)</p> <p>1659 : Influenza Immunization</p> <p>5a.1 Are specs completely harmonized? No</p> <p>5a.2 If not completely harmonized, identify difference, rationale,</p>

	0039 Flu Vaccinations for Adults Ages 18 and Older	0041 Preventive Care and Screening: Influenza Immunization	0226 Influenza Immunization in the ESRD Population (Facility Level)	0431 Influenza Vaccination Coverage Among Healthcare Personnel	0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)	0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)	1659 Influenza Immunization	3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)
	<p>5a.2 If not completely harmonized, identify difference, rationale, impact: Measure 0039 is the only measure collected through patient survey. This measure is collected through the CAHPS 5.0 Adult Survey. We specify collecting this measure through a survey because many adult flu vaccinations are given outside of the traditional medical setting (e.g. at work or in retail flu clinics) and are therefore less likely to be documented in a medical record or claim.</p> <p>5b.1 If competing, why superior or rationale for additive value: NCQA views these measures as complementary to each other; each supporting the goal of protecting the individual and the population from active influenza viruses.</p>	<p>impact: Related measures have differing target populations from measure 0041 Preventive Care and Screening: Influenza Immunization. Measure #0041 is intended to evaluate adherence to the current recommendations of the Advisory Committee on Immunization Practices. The Committee recommends routine annual influenza vaccination for all persons aged >=6 months who do not have contraindications. Measure #0039 - Flu Vaccinations for Adults ages 18 and Older focuses on the self-reported receipt of influenza vaccination among adults using the CAHPS survey. Measure #0226 – Influenza Immunization in the ESRD Population is a facility level measure focused on influenza vaccination among end stage renal disease (ESRD) patients receiving hemodialysis or peritoneal dialysis. Measure #0431 - Influenza Vaccination Coverage Among Healthcare Personnel focuses on influenza vaccination among healthcare workers. Measure #0522 Influenza Immunization Received for Current Flu Season (Home Health) evaluates influenza immunization during home health episodes of care. Measure # 0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay) applies to patients of Inpatient</p>	<p>5a.1 Are specs completely harmonized? Yes</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable.</p> <p>5b.1 If competing, why superior or rationale for additive value: No known competing measures.</p>		<p>Influenza and Pneumococcal Immunizations. A possible competing measure is the National Committee for Quality Assurance (NCQA) measure titled: Flu vaccinations for adults ages 65 and older: percentage of Medicare members 65 years of age and older who received an influenza vaccination between July 1 of the measurement year and the date when Medicare CAHPS survey was completed.</p> <p>This NCQA measure is based on the CAHPS Health Plan Survey and targets a different and non-institutionalized population, so while this is a related measure, it does not complete with NQF #0680, which provides distinctive value.</p> <p>Another possible competing measure for IRFs and LTCHs is NQF #1659 titled: Influenza Immunization for Hospital/Acute Care Facility AND Institute for Clinical Systems (ICS). The measure suggests immunizations of adult patients 18 years and older to be up to date with all immunization vaccines with follow up time periods.</p> <p>NQF #1659 targets a different population in multiple settings and does not include those assessed but not given the vaccine. ICS is not NQF endorsed and has a different target population with a broader</p>	<p>Set is the data source for LTCHs). Both NQF #0680 and the current measure #0681 for long stay nursing home residents were developed together and harmonized to the NQF Voluntary Consensus Standards for Influenza Immunizations and each other as much as possible. A possible competing measure is NQF #1659: Influenza Immunization for Hospital/Acute Care Facility AND Institute for Clinical Systems (ICS) suggest immunizations of adult patients 18 years and older, to be up to date with all immunization vaccines with follow up time periods. NQF #1659 targets a different population in a different setting and does not include those assessed but not given the vaccine. ICS is not NQF endorsed and has a different target population with a broader numerator (multiple other vaccines). NQF #0680 targets a different population in multiple settings.</p> <p>Another possible competing measure is the National Committee for Quality Assurance (NCQA) measure titled: Flu vaccinations for adults ages 65 and older: percentage of Medicare members 65 years of age and older who received an influenza vaccination between July 1 of the measurement year and the date when Medicare CAHPS survey was completed.</p>	<p>5a.2 If not completely harmonized, identify difference, rationale, impact: Measures focus on different patient populations based on age, health conditions or location (e.g., home health, physician office, short term skilled, long term stay, acute care hospital, etc.). There are some differences in Exclusions and Inclusions specific to the population. These differences are in part based upon procedures that may be performed in an acute care hospital that would not be performed in a skilled setting or physician office setting. Additionally IMM-2 excludes cases in which the vaccine has been ordered but it has not yet been received. We've found in the past that there have been some seasons in which the vaccine became available much later than expected and seasons in which there were shortages. We prefer to exclude these cases if there is documentation in the chart to support either of these scenarios</p> <p>5b.1 If competing, why superior or rationale for additive value: Multiple measures are justified because they each focus on a different patient population. A single measure could not capture the variability inherent in these different populations.</p> <p>IMM-2 is the only measure that focuses on patients in</p>	<p>impact: Related measures have differing target populations from measure 0041 Preventive Care and Screening: Influenza Immunization. Measure #0041 is intended to evaluate adherence to the current recommendations of the Advisory Committee on Immunization Practices for all persons aged >=6 months who do not have contraindications. Measure #0039 - Flu Vaccinations for Adults ages 18 and Older focuses on the self-reported receipt of influenza vaccination among adults using the CAHPS survey. Measure #0226 – Influenza Immunization in the ESRD Population is a facility level measure focused on influenza vaccination among end stage renal disease (ESRD) patients receiving hemodialysis or peritoneal dialysis. Measure #0431 - Influenza Vaccination Coverage Among Healthcare Personnel focuses on influenza vaccination among healthcare workers. Measure #0522 Influenza Immunization Received for Current Flu Season (Home Health) evaluates influenza immunization during home health episodes of care. Measure # 0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay) applies to patients of Inpatient Rehabilitation Facilities and Long-Term Care Hospitals, and to short-stay</p>

	0039 Flu Vaccinations for Adults Ages 18 and Older	0041 Preventive Care and Screening: Influenza Immunization	0226 Influenza Immunization in the ESRD Population (Facility Level)	0431 Influenza Vaccination Coverage Among Healthcare Personnel	0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)	0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)	1659 Influenza Immunization	3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)
		<p>Rehabilitation Facilities and Long-Term Care Hospitals, and to short-stay nursing home residents. Measure #0681 - Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay) assess influenza vaccination among long-stay nursing facility residents. Measure #1659 Influenza Immunization is limited to the assessment of influenza vaccination upon discharge from the inpatient setting.</p> <p>5b.1 If competing, why superior or rationale for additive value:</p>			<p>numerator (multiple other vaccines). NQF #0680 targets a different population in multiple settings, so while it is a related measure, it does not compete with NQF# 0680.</p>	<p>This NCQA measure is based on the CAHPS Health Plan Survey and targets a different and non-institutionalized population, so NQF #0681 offers distinctive value.</p>	<p>the acute care hospital setting.</p>	<p>nursing home residents. Measure #0681 - Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay) assess influenza vaccination among long-stay nursing facility residents. Measure #1659 Influenza Immunization is limited to the assessment of influenza vaccination upon discharge from the inpatient setting.</p> <p>5b.1 If competing, why superior or rationale for additive value:</p>

Appendix F2: Related and Competing Measures (narrative format)

Comparison of NQF #0039, NQF #0041, NQF #0226, NQF #0431, NQF #0680, NQF #0681, NQF #1659, and NQF #3070

0039 Flu Vaccinations for Adults Ages 18 and Older

0041 Preventive Care and Screening: Influenza Immunization

0226 Influenza Immunization in the ESRD Population (Facility Level)

0431 Influenza Vaccination Coverage Among Healthcare Personnel

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

1659 Influenza Immunization

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

Steward

0039 Flu Vaccinations for Adults Ages 18 and Older

National Committee for Quality Assurance

0041 Preventive Care and Screening: Influenza Immunization

PCPI Foundation

0226 Influenza Immunization in the ESRD Population (Facility Level)

Kidney Care Quality Alliance

0431 Influenza Vaccination Coverage Among Healthcare Personnel

Centers for Disease Control and Prevention

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

Centers for Medicare & Medicaid Services

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

Centers for Medicare & Medicaid Services

1659 Influenza Immunization

Centers for Medicare and Medicaid Services

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

PCPI Foundation

Description

0039 Flu Vaccinations for Adults Ages 18 and Older

The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure is collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, and commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.

0041 Preventive Care and Screening: Influenza Immunization

Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

0226 Influenza Immunization in the ESRD Population (Facility Level)

Percentage of end stage renal disease (ESRD) patients aged 6 months and older receiving hemodialysis or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31 who either received, were offered and declined, or were determined to have a medical contraindication to the influenza vaccine.

0431 Influenza Vaccination Coverage Among Healthcare Personnel

Percentage of healthcare personnel (HCP) who receive the influenza vaccination.

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

The measure reports the percentage of short-stay residents or patients who are assessed and appropriately given the seasonal influenza vaccine during the most recently-completed influenza season. The influenza vaccination season (IVS) is defined as beginning on October 1, or when the vaccine first becomes available*, and ends on March 31 of the following year. This measure is based on the NQF's National Voluntary Standards for Influenza and Pneumococcal Immunizations.

The measure is the aggregate of three separately calculated submeasures to reflect the process by which a resident or patient is assessed and appropriately given the influenza vaccination during the current or most recent influenza season.

The three submeasures are as follows:

- residents or patients who received the influenza vaccine during the most recently completed influenza season, either in the facility/hospital or outside the facility/hospital (NQF #0680a);
- residents or patients who were offered and declined the seasonal influenza vaccine (NQF #0680b);
- residents or patients who were ineligible to receive the seasonal influenza vaccine due to contraindication(s) (e.g., anaphylactic hypersensitivity to eggs or other components of the vaccine, see <http://www.cdc.gov/flu/professionals/vaccination/vax-summary.htm>) (NQF #0680c).

*Note: While the IVS officially begins when the vaccine becomes available, which may be before October 1, the denominator time window for the quality measure and references to the IVS for the denominator specification is from October 1 to March 31 of the following year. The numerator time window and references to the IVS in the numerator specifications may include patients and residents who are assessed and offered the vaccine before October 1. This is based on how the influenza items were coded by the facility.

The denominator consists of patients or short-stay residents 180 days of age or older on the target date of assessment who were in the facility/hospital for at least one day during the most recently-completed influenza vaccination season (IVS). The measure is based on data from the Minimum Data Set (MDS) assessments of nursing home residents, Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) assessments for Inpatient

Rehabilitation Facility (IRF) patients, and the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set Version assessments of LTCH patients. Data are collected in each of these three settings using standardized items across the three assessment instruments. For the nursing homes, the measure is limited to short-stay residents, identified as residents who have had 100 or fewer days of nursing home care. For the LTCHs, this measure will include all patients, irrespective of a patient's length of stay. For IRFs, this measure includes all Medicare Part A and Part C patients, irrespective of a patient's length of stay.

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

This measure reports the percentage of long-stay residents, 180 days of age and older, who were in a nursing facility for at least one day during the most recently completed influenza vaccination season (IVS), and who were assessed and appropriately given the seasonal influenza vaccine. The IVS is defined as beginning on October 1 and ends on March 31 of the following year. The measure is the aggregate of three separately calculated submeasures to reflect the process by which a resident is assessed and appropriately given the influenza vaccination during the current or most recent influenza season.

The three submeasures are as follows:

- resident received the influenza vaccine during the current or most recent influenza season, either in the facility or outside the facility (NQF #0681a);
- resident was offered and declined the seasonal influenza vaccine (NQF #0681b); and
- resident was ineligible to receive the seasonal influenza vaccine due to contraindication(s) (e.g., anaphylactic hypersensitivity to eggs or other components of the vaccine, see <http://www.cdc.gov/flu/professionals/vaccination/vax-summary.htm>) (NQF #0681c).

The denominator consists of long-stay residents 180 days of age or older on the target date of assessment who were in the facility for at least one day during the most recently-completed influenza vaccination season (IVS). This measure is based on data from the Minimum Data Set (MDS 3.0) OBRA, PPS, and/or discharge assessments during the selected influenza season. Long-stay residents are identified as those who have had 101 or more cumulative days of nursing facility care.

A separate measure (NQF #0680, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)) is to be used for residents who have had 100 or fewer cumulative days of nursing facility care.

1659 Influenza Immunization

Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

Type

0039 Flu Vaccinations for Adults Ages 18 and Older

Process

0041 Preventive Care and Screening: Influenza Immunization

Process

0226 Influenza Immunization in the ESRD Population (Facility Level)

Process

0431 Influenza Vaccination Coverage Among Healthcare Personnel

Process

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

Process

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

Process

1659 Influenza Immunization

Process

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

Process

Data Source

0039 Flu Vaccinations for Adults Ages 18 and Older

Patient Reported Data/Survey This survey can be administered by mail, telephone, or internet. It is offered in English and Spanish. Organizations may use their own translation of the survey with approval of NCQA.

Available at measure-specific web page URL identified in S.1 No data dictionary

0041 Preventive Care and Screening: Influenza Immunization

Electronic Clinical Data, Electronic Clinical Data : Registry Not applicable

No data collection instrument provided No data dictionary

0226 Influenza Immunization in the ESRD Population (Facility Level)

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records The necessary data elements are to be collected via the CMS CROWNWeb data repository.

No data collection instrument provided No data dictionary

0431 Influenza Vaccination Coverage Among Healthcare Personnel

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Management Data, Paper Medical Records, Patient Reported Data/Survey Data sources for required data elements include management/personnel data, medical or occupational health records, vaccination record documents, HCP self-reporting in writing (paper or electronic) that

vaccination was received elsewhere, HCP providing documentation of receipt of vaccine elsewhere, verbal or written declination by HCP, and verbal or written documentation of medical contraindications.

Available at measure-specific web page URL identified in S.1 Attachment HCP Flu Data Dictionary-635049906022226964.docx

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

Electronic Clinical Data Nursing Home Minimum Data Set 3.0, Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), LTCH Continuity Assessment Record & Evaluation (Care) Data Set

Available at measure-specific web page URL identified in S.1 No data dictionary

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

Electronic Clinical Data Nursing Home Minimum Data Set 3.0

Available at measure-specific web page URL identified in S.1 No data dictionary

1659 Influenza Immunization

Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Medical Records An electronic data collection tool is made available from vendors or facilities can download the free CMS Abstraction & Reporting Tool (CART). Paper tools for manual abstraction, which are posted on www.QualityNet.org, are also available for the CART tool. These tools are posted on www.QualityNet.org.

Available at measure-specific web page URL identified in S.1 Attachment Appendix_A.Table_12.10_Organ_Transplant_ICD-10__ICD-9_codes.xls

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Not applicable
No data collection instrument provided Attachment CMS147v6_Preventive-Influenza_PCPI_valuesets_APRIL2016.xlsx

Level

0039 Flu Vaccinations for Adults Ages 18 and Older

Health Plan, Integrated Delivery System

0041 Preventive Care and Screening: Influenza Immunization

Clinician : Group/Practice, Clinician : Individual

0226 Influenza Immunization in the ESRD Population (Facility Level)

Facility

0431 Influenza Vaccination Coverage Among Healthcare Personnel

Facility

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

Facility

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

Facility

1659 Influenza Immunization

Facility

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

Clinician : Group/Practice, Clinician : Individual

Setting

0039 Flu Vaccinations for Adults Ages 18 and Older

Ambulatory Care : Clinician Office/Clinic, Home Health, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Pharmacy, Ambulatory Care : Urgent Care

0041 Preventive Care and Screening: Influenza Immunization

Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Other Domiciliary

0226 Influenza Immunization in the ESRD Population (Facility Level)

Dialysis Facility

0431 Influenza Vaccination Coverage Among Healthcare Personnel

Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

1659 Influenza Immunization

Hospital/Acute Care Facility

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Other Domiciliary

Numerator Statement

0039 Flu Vaccinations for Adults Ages 18 and Older

This measure is reported as two rates:

Flu Vaccination for Adults age 18-64 – Respondents to the Medicaid or commercial CAHPS survey who report having received an influenza vaccination since July of the previous year.

Flu Vaccination for Adults age 65+ - Respondents to the Medicare CAHPS survey who report having received an influenza vaccination since July of the previous year.

0041 Preventive Care and Screening: Influenza Immunization

Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

0226 Influenza Immunization in the ESRD Population (Facility Level)

Number of patients from the denominator who:

1. received an influenza vaccination,* documented by the provider or reported receipt from another provider by the patient (computed and reported separately);

OR

2. were assessed and offered an influenza vaccination but declined (computed and reported separately);

OR

3. were assessed and determined to have a medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, and/or bone marrow transplant within the past 6 months (<6 months prior to encounters between October 1 and March 31) (computed and reported separately).

*Only inactivated vaccine should be used in the ESRD population.

0431 Influenza Vaccination Coverage Among Healthcare Personnel

HCP in the denominator population who during the time from October 1 (or when the vaccine became available) through March 31 of the following year:

(a) received an influenza vaccination administered at the healthcare facility, or reported in writing (paper or electronic) or provided documentation that influenza vaccination was received elsewhere; or

(b) were determined to have a medical contraindication/condition of severe allergic reaction to eggs or to other component(s) of the vaccine, or history of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination; or

(c) declined influenza vaccination; or

(d) persons with unknown vaccination status or who do not otherwise meet any of the definitions of the above-mentioned numerator categories.

Numerators are to be calculated separately for each of the above groups.

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

The numerator for the overall measure (NQF #0680) is the number of residents or patients in the denominator sample who, during the numerator time window, meet any one of the

following criteria: (1) those who received the seasonal influenza vaccine during the most recently-completed influenza season, either in the facility/hospital or outside the facility/hospital (NQF #0681a); (2) those who were offered and declined the seasonal influenza vaccine (NQF #0681b); or (3) those who were ineligible due to contraindication(s) (NQF #0681c). The numerator time window coincides with the most recently-completed seasonal IVS which begins on October 1 and ends on March 31 of the following year.

Each of the three submeasures numerators described above will be computed and reportedly separately, alongside the overall numerator calculated as the aggregate of the three submeasure numerators.

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

The numerator is the number of long-stay residents with a target assessment (OBRA admission, quarterly, annual or significant change/correction assessments; PPS 5-,14-, 30-, 60-, 90-day, or readmission/return assessments; or discharge assessment with or without return anticipated) who were in the denominator sample, AND who meet any of the following criteria for the selected influenza season: (1) they received the influenza vaccine during the most recent influenza season, either in the facility or outside the facility (NQF #0681a), (2) they were offered and declined the influenza vaccine (NQF #0681b), or (3) they were ineligible due to medical contraindication(s) (NQF #0681c). The influenza season is defined as July 1 of the current year to June 30 of the following year. The IVS begins on October 1 and ends on March 31 of the following year.

Each of the three submeasure numerators described above will be computed and reported separately, alongside the overall numerator calculated as the aggregate of the three submeasure numerators.

1659 Influenza Immunization

Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated.

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

Numerator Details

0039 Flu Vaccinations for Adults Ages 18 and Older

Flu Vaccinations for Adults Ages 18-64 – CAHPS respondents answering “yes” to the question: “Have you had either a flu shot or flu spray in the nose since July 1, YYYY?” where YYYY is the measurement year (e.g. 2014 for the survey fielded in 2015). Response Choices: “Yes, No, Don’t know”

Flu Vaccination for Adults Age 65 and Older – CAHPS respondents answering “yes” to the question: “Have you had a flu shot or flu spray since July 1, YYYY?” where YYYY is the measurement year (e.g. 2014 for the survey fielded in 2015). Response Choices: “Yes, No, Don’t know”

0041 Preventive Care and Screening: Influenza Immunization

For Registry:

NUMERATOR DEFINITION:

Previous Receipt – Receipt of the current season’s influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).

NUMERATOR GUIDANCE:

The numerator for this measure can be met by reporting either administration of an influenza vaccination or that the patient reported previous receipt of the current season’s influenza immunization. If the performance of the numerator is not met, an eligible clinician can report a valid Denominator Exception for having not administered an influenza vaccination.

NUMERATOR SPECIFICATION:

Report one of the following options:

CPT Code for Influenza Immunization:

- 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90664, 90666, 90667, 90668, 90672, 90673, 90685, 90686, 90687, 90688

OR

Quality data code for Influenza Immunization or Prior Receipt:

- G8482: Influenza immunization administered or previously received

0226 Influenza Immunization in the ESRD Population (Facility Level)

Include in the numerator all patients from the denominator who:*

1. Received an influenza vaccination** (documented by the provider or reported receipt from another provider by the patient).
2. Were assessed and offered an influenza vaccination but declined.
3. Were assessed and were determined to have a medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, and/or bone marrow transplant within the past 6 months (<6 months prior to encounters between October 1 and March 31).

*Each of the 3 numerator subcategories are to be computed and reported separately.

**Only inactivated vaccine should be used in the ESRD population.

0431 Influenza Vaccination Coverage Among Healthcare Personnel

1. Persons who declined vaccination because of conditions other than those specified in the 2nd numerator category above should be categorized as declined vaccination.
2. Persons who declined vaccination and did not provide any other information should be categorized as declined vaccination.
3. Persons who did not receive vaccination because of religious or philosophical exemptions should be categorized as declined vaccination.
4. Persons who deferred vaccination all season should be categorized as declined vaccination.
5. The numerator categories are mutually exclusive. The sum of the four numerator categories should be equal to the denominator.

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

The numerator for the overall measure (NQF #0680) includes all patients or short-stay residents in the denominator sample who, during the numerator time window, meet one of three criteria: (1) received the seasonal influenza vaccine during the most recent influenza season, either inside or outside the facility/hospital, (2) were offered and declined the vaccine, or (3) were ineligible due to medical contraindications.

For each setting (i.e., nursing homes, inpatient rehabilitation facilities, and long-term care hospitals), the numerator components are also computed and reported separately as a submeasure.

Specifications for the three provider type assessment tools are listed below:

MDS: Residents are counted if they are short-stay residents, defined as residents whose length of stay is less than or equal to 100 days. Short-stay residents are included in the numerator for the overall measure (NQF #0680) if they meet any of the following criteria during the numerator time window: (1) received the influenza vaccine during the most recent influenza vaccine season, either in the facility (O0250A=1) or outside the facility (O0250C=2) (also computed and reported separately as a submeasure); or (2) offered and declined the influenza vaccine (O0250C=4) (also computed and reported separately as a submeasure); or (3) ineligible due to medical contraindication(s) (O0250C=3) (also computed and reported separately as a submeasure). Included in the numerator are short-stay residents who meet the criteria on the selected MDS assessment. The record selected will be the record with the latest target date that meets all of the following conditions: (1) it has a qualifying reason for assessment (OBRA (A0310A=01,02,03,04,05,06), PPS (A0310B=01,02,03,04,05,06) or discharge assessment (A0310F=10, 11), (2) the target date is on or after October 1st of the most recently completed influenza season, and (3) the entry date is on or before March 31st of the most recently completed influenza season.

IRF-PAI: Patients are included in the numerator for the overall measure (NQF #0680) for stays that meet any of the following criteria during the numerator time window: (1) received the influenza vaccine during the most recently-completed influenza season, either in the facility (O0250A = 1) or outside the facility (O0250C = 2) ; or (2) offered and declined the influenza vaccine (O0250C = 4; or (3) ineligible due to medical contraindication(s) (O0250C = 3). All three of these also computed and reported separately as submeasures. Included in the numerator are patients who meet the criteria based on data reported on the IRF-PAI assessments during the denominator time window. Note: IRF-PAI assessments are submitted to CMS for Medicare Part A and Part C patients.

LTCH CARE Data Set (LCDS): Patients are included in the numerator for the overall measure (NQF #0680) for patient stays that meet any of the following criteria during the numerator time window: (1) received the influenza vaccine during the most recent influenza season, either in the facility (O250A=1) or outside the facility (O0250C=2) ; or (2) offered and declined the influenza vaccine (O0250C=4); or (3) ineligible due to medical contraindication(s) (O0250C=3).All three of these also computed and reported separately as submeasures. Included in the numerator are patients who meet the criteria on the LTCH CARE Data Set admission assessment (A0250=01), discharge or expired patient assessment (A0250=10, 11, 12) during the denominator time window. Note: LCDS expired assessments

(A0250=12) completed before April 1, 2016 are not included in the numerator because prior to this date the influenza items were not included on expired assessments.

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

Residents are counted if they are long-stay residents, defined as residents who have had 101 or more cumulative days of nursing facility care, are 180 days of age and older and who were in a nursing facility for at least one day during the most recently completed IVS. Residents who return to the nursing home following a hospital discharge will not have their stay reset to zero. The numerator is the number of long-stay residents in the denominator sample with a selected target assessment (OBRA admission, quarterly, annual or significant change/correction assessments; PPS 5-, 14-, 30-, 60-, 90-day, or readmission/return assessments; or discharge assessment with or without return anticipated) during the most recently selected influenza season who meet any of the following criteria:

- (1) Resident received the influenza vaccine during the most recent influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]) (NQF #0681a, computed separately); or
- (2) Resident was offered and declined the influenza vaccine (O0250C = [4]) (NQF #0681b, computed separately); or
- (3) Resident was ineligible due to contraindication(s) (O0250C = [3]) (NQF #0681c, computed separately) (e.g., anaphylactic hypersensitivity to eggs or other components of the vaccine).

1659 Influenza Immunization

The following are included in the numerator:

- Patients who received the influenza vaccine during this inpatient hospitalization
- Patients who received the influenza vaccine during the current year's flu season but prior to the current hospitalization
- Patients who were offered and declined the influenza vaccine
- Patients who have an allergy/sensitivity to the influenza vaccine, anaphylactic latex allergy or anaphylactic allergy to eggs, or for whom the vaccine is not likely to be effective because of bone marrow transplant within the past 6 months, or history of Guillian-Barre Syndrome within 6 weeks after a previous influenza vaccination

Data Elements required for the numerator:

- ICD-10-CM Other Diagnosis Codes
- ICD-10-PCS Other Procedure Codes
- ICD-10-CM Principal Diagnosis Code
- ICD-10-PCS Principal Procedure Code
- Influenza Vaccination Status

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

For EHR:

Health Quality Measures Format (HQMF) eMeasure developed and is attached to this submission in field S.2a.

We have provided the following definitions and/or guidance for convenience; please see HQMF eMeasure for complete details related to the specification.

NUMERATOR DEFINITION:

Previous Receipt - receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st)

Denominator Statement

0039 Flu Vaccinations for Adults Ages 18 and Older

Flu Vaccinations for Adults Ages 18-64 – Medicaid and Commercial CAHPS respondents age 18-64

Flu Vaccination for Adults Age 65 and Older – Medicare CAHPS respondents age 65 and older.

0041 Preventive Care and Screening: Influenza Immunization

All patients aged 6 months and older seen for a visit between October 1 and March 31

0226 Influenza Immunization in the ESRD Population (Facility Level)

All ESRD patients aged 6 months and older receiving hemodialysis and/or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31.

0431 Influenza Vaccination Coverage Among Healthcare Personnel

Number of HCP who are working in the healthcare facility for at least 1 working day between October 1 and March 31 of the following year, regardless of clinical responsibility or patient contact.

Denominators are to be calculated separately for:

(a) Employees: all persons who receive a direct paycheck from the reporting facility (i.e., on the facility's payroll).

(b) Licensed independent practitioners: include physicians (MD, DO), advanced practice nurses, and physician assistants only who are affiliated with the reporting facility who do not receive a direct paycheck from the reporting facility.

(c) Adult students/trainees and volunteers: include all students/trainees and volunteers aged 18 or over who do not receive a direct paycheck from the reporting facility.

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

The denominator consists of patients or short-stay residents 180 days of age and older on the target date of the assessment who were in the facility/hospital for at least one day during the denominator time window. The denominator time window is defined as the most recently-completed IVS, from October 1 to March 31 of the following year. For IRF and LTCH, the QM is based on completed patient stays (have discharge assessments). An IRF or LTCH patient with multiple stays during the denominator time window (IVS) will be included more than once in the QM. If a nursing home resident has more than one episode during the denominator time window only the more recent episode is included in this QM.

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

The denominator is the total number of long-stay residents 180 days of age or older on the target date of the assessment who were in the nursing facility who were in a nursing facility for at least one day during the most recently completed IVS that have an OBRA, PPS, or discharge assessment and who did not meet the exclusion criteria.

1659 Influenza Immunization

Acute care hospitalized inpatients age 6 months and older discharged during the months of October, November, December, January, February or March.

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

All patients aged 6 months and older seen for a visit between October 1 and March 31

Denominator Details

0039 Flu Vaccinations for Adults Ages 18 and Older

Flu Vaccination for Adults Ages 18-64 - The number of patients age 18-64 who responded “Yes” or “No” to the question “Have you had either a flu shot or flu spray in the nose since July 1, YYYY?”

Flu Vaccination for Adults Age 65 and Older – The number of patients age 65 and older who responded “Yes” or “No” to the question, “Have you had a flu shot or flu spray in the nose since July 1, YYYY?”

0041 Preventive Care and Screening: Influenza Immunization

For Registry:

DENOMINATOR SPECIFICATION:

Age >= 6 months

AND

At least one encounter during measurement period (CPT or HCPCS): 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, 99512, G0438, G0439

0226 Influenza Immunization in the ESRD Population (Facility Level)

Include in the denominator all patients within a facility who meet the following criteria during the time from October 1 (or when the influenza vaccine became available) to March 31 of the reporting year:

1. Diagnosis = ESRD

AND

2. Primary type of dialysis = hemodialysis, home hemodialysis, continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), or nighttime intermittent peritoneal dialysis (NIPD).

AND

3. Age = \geq 6 months

0431 Influenza Vaccination Coverage Among Healthcare Personnel

1. Include all HCP in each of the denominator categories who have worked at the facility between October 1 and March 31 for at least 1 working day. This includes persons who joined after October 1 or who left before March 31, or who were on extended leave during part of the reporting period. Working for any number of hours in a day should be counted as a working day.
2. Include both full-time and part-time personnel. If a person works in two or more facilities, each facility should include the person in their denominator.
3. Count persons as individuals rather than full-time equivalents.
4. Licensed practitioners who receive a direct paycheck from the reporting facility, or who are owners of the reporting facility, should be counted as employees.
5. The denominator categories are mutually exclusive. The numerator data are to be reported separately for each of the denominator categories.

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

The denominator time window is defined as the most recently-completed IVS, from October 1 to March 31 of the following year. Measure specifications for the three assessment tools are listed below. For IRF and LTCH, the QM is based on stays with admission and discharge assessments. An IRF or LTCH patient with multiple stays during the denominator time window (IVS) will be included more than once in the QM. If a nursing home resident has more than one episode during the denominator time window only the more recent episode is included in this QM.

MDS (in use in Nursing Homes/Skilled Nursing Facilities): Residents are counted if they are short-stay residents, defined as residents whose length of stay is less than or equal to 100 days. The sample includes residents, aged 180 days or older, meeting the following conditions: the resident has an OBRA assessment (A0310A=01,02,03,04,05,06) or PPS assessment (A0310B=01,02,03,04,05,06) or discharge assessment (A0310F=10, 11) with an assessment reference date on or after the start of the denominator time window and an entry date (A1600) on or before the end of the denominator time window.

IRF-PAI (in use in Inpatient Rehabilitation Facilities): Patient stays are included in the sample if patients are 180 days or older and have a stay that includes 1 or more days in the IRF during the denominator time window (the IVS). Patient stays must meet any of the following conditions: (1) the patient has an admission assessment with an entry date (item 12) during the denominator time window; (2) the patient has a discharge assessment with a discharge date (Item 40) during the denominator time window; or (3) the patient has an admission with an entry date (item 12) before the denominator time window and a discharge date (item 40) after the denominator time window.

LTCH CARE Data Set (in use in Long-Term Care Hospitals): Patient stays are included in the sample if patients are 180 days of age or older at discharge and have a stay that includes 1 or more days in the LTCH during the denominator time window. Stays must meet either of the following conditions: (1) a stay with an admission date (A0220) or a planned or unplanned (A0250 = 10, 11) discharge date (A0270) or an expired patient assessment (A0250 = 12) within the denominator time window; or (2) a stay with the admission date

(A0220) before the denominator time window and a planned or unplanned discharge (A0250 = 10, 11) with discharge or date (A0270) or a patient expired assessment (A0250 = 12) with date of death (A0270) after the denominator time window.

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

Residents are counted if they are long-stay residents, defined as residents who have had 101 or more cumulative days of nursing facility care. Residents who return to the nursing home following a hospital discharge will not have their length of stay reset to zero. The target population includes all long-stay residents with a target assessment (assessments may be OBRA admission, quarterly, annual or significant change/correction assessments (A0310A = 01, 02, 03, 04, 05, 06) or PPS 5-, 14-, 30-, 60-, 90-day, or readmission/return assessments (A0310B = 01, 02, 03, 04, 05, 06) or discharge assessment with or without return anticipated (A0310F = 10, 11) who were in a nursing facility for at least one day during the most recently completed IVS, except for those who meet the exclusion criteria (specified in S.10 and S.11).

1659 Influenza Immunization

Data Elements required for the denominator:

- Admission Date
- Birthdate
- Discharge Date
- Discharge Disposition
- ICD-10-PCS Other Procedure Codes
- ICD-10-PCS Principal Procedure Code

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

For EHR:

HQMF eMeasure developed and is attached to this submission in field S.2a.

We have provided the following definitions and/or guidance for convenience; please see HQMF eMeasure for complete details related to the specification.

DENOMINATOR GUIDANCE:

The timeframe for the visit during the "Encounter, Performed: Encounter-Influenza" or "Procedure, Performed: Peritoneal Dialysis" or "Procedure, Performed: Hemodialysis" in the Population Criteria-Denominator, refers to the influenza season defined by the measure: October through March (October 1 for the year prior to the start of the reporting period through March 31 during the reporting period). The "Encounter-Influenza" Grouping OID detailed in the data criteria section below is comprised of several individual OIDs of different encounter types. The individual OIDs are included in the value set and should be reviewed to determine that an applicable visit occurred during the timeframe for "Encounter, Performed: Encounter-Influenza" as specified in the denominator.

To enable reporting of this measure at the close of the reporting period, this measure will only assess the influenza season that ends in March of the reporting period. The subsequent influenza season (ending March of the following year) will be measured and reported in the following year.

To account for the majority of reporting years' appropriate flu season duration, the measure logic will look at the first 89 days of the measurement period for the appropriate criteria and actions to be present/performed (January 1 through March 31). The measure developer believes it is best to keep the logic as static as possible from one reporting year to the next. Therefore, during leap years, only encounters that occur through March 30 will be counted in the denominator.

Exclusions

0039 Flu Vaccinations for Adults Ages 18 and Older

N/A

0041 Preventive Care and Screening: Influenza Immunization

Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons)

Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons)

Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons)

0226 Influenza Immunization in the ESRD Population (Facility Level)

None.

0431 Influenza Vaccination Coverage Among Healthcare Personnel

None.

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

Residents or patients whose age is 179 days or less on target date of the selected influenza vaccination assessment are excluded. LTCH patients whose expired assessments are completed before April 1, 2016 are excluded. After April 1, 2016 expired patients are no longer excluded from the QM, because the influenza items were added to the LCDS expired assessments. Nursing homes with denominator counts of less than 20 residents and IRFs and LTCHs with less than 20 stays in the sample are excluded from public reporting due to small sample size.

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

Residents whose age is 179 days or less on target date of selected influenza vaccination assessment are excluded.

If the facility sample includes fewer than 30 residents after all other resident-level exclusions are applied, then the facility is excluded from public reporting.

1659 Influenza Immunization

The following patients are excluded from the denominator:

- Patients less than 6 months of age
- Patients who expire prior to hospital discharge
- Patients with an organ transplant during the current hospitalization (Appendix_A.Table 12.10 Organ Transplant codes.xls)

- Patients for whom vaccination was indicated, but supply had not been received by the hospital due to problems with vaccine production or distribution
- Patients who have a Length of Stay greater than 120 days
- Patients who are transferred or discharged to another acute care hospital
- Patients who leave Against Medical Advice (AMA)

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons)

Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons)

Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons)

Exclusion Details

0039 Flu Vaccinations for Adults Ages 18 and Older

N/A

0041 Preventive Care and Screening: Influenza Immunization

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure on Preventive Care and Screening: Influenza Immunization, exceptions may include medical reason(s) (eg, patient allergy); patient reason(s) (eg, patient declined); or system reason(s) for the patient not receiving influenza immunization (eg, vaccine not available). Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Additional details by data source are as follows:

For Registry:

DENOMINATOR EXCEPTION GUIDANCE:

For eligible clinicians reporting a Denominator Exception for this measure, there should be a clear rationale and documented reason for not administering an influenza immunization if the patient did not indicate previous receipt, which could include a medical reason (eg, patient allergy, other medical reason), patient reason (eg, patient declined, other patient reason), or system reason (eg, vaccination not available, other system reason). The system

reason should be indicated only for cases of disruption or shortage of influenza vaccination supply.

DENOMINATOR EXCEPTION SPECIFICATION:

To report a denominator exception, report the following quality data code:

G8483: Influenza immunization was not administered for reasons documented by clinician (eg, patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons)

0226 Influenza Immunization in the ESRD Population (Facility Level)

Not applicable.

0431 Influenza Vaccination Coverage Among Healthcare Personnel

Not applicable.

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

Residents or patients with age 179 days or less are excluded, with age calculation based on the resident and patient birthdate and the target date of the selected influenza vaccination assessment.

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

Residents whose age is 179 days or less are excluded, with age calculation based on the resident birthdate and the target date of the selected influenza vaccination assessment.

1659 Influenza Immunization

To determine the length of stay, the admission date and discharge date are entered. If the result of the calculation subtracting the admission date from the discharge date is greater than 120 days the patient is excluded from the measure.

The patient's date of birth is entered. If the calculation result of the admission date minus the birth date is less than 6 months the patient is excluded from the measure.

Patients who had an organ transplant during the current hospitalization are excluded based on having an ICD-10 PCS Principal or Other Procedure Code assigned as having occurred during the current hospitalization. If the patient has at least one code from the list on Appendix_A.Table 12.10 Organ Transplant codes.xls assigned for the current hospitalization they are excluded.

Discharge Disposition is a manually abstracted data element. If documentation in the patient's medical record is consistent with the criteria specified in the Discharge Disposition data element for discharge to an acute care facility, patient expired prior to hospital discharge, or the patient left against medical advice the patient is excluded from the measure.

The Influenza Vaccination Status is a manually abstracted data element for the measure. Allowable Value 6 may be selected if there is documentation in the medical record reflecting the hospital has ordered the influenza vaccine but has not yet received it based on problems with vaccine production or distribution. If this value is selected the measure algorithm will exclude the patient from the measure.

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure on Preventive Care and Screening: Influenza Immunization, exceptions may include medical reason(s) (eg, patient allergy); patient reason(s) (eg, patient declined); or system reason(s) for the patient not receiving influenza immunization (eg, vaccine not available). Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Additional details by data source are as follows:

For EHR:

HQMF eMeasure developed and is attached to this submission in field S.2a.

Risk Adjustment

0039 Flu Vaccinations for Adults Ages 18 and Older

No risk adjustment or risk stratification

N/A

0041 Preventive Care and Screening: Influenza Immunization

No risk adjustment or risk stratification

No risk adjustment or risk stratification.

0226 Influenza Immunization in the ESRD Population (Facility Level)

No risk adjustment or risk stratification

Not applicable.

0431 Influenza Vaccination Coverage Among Healthcare Personnel

No risk adjustment or risk stratification

Not applicable.

Provided in response box S.15a

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

No risk adjustment or risk stratification

This section is not applicable.

Provided in response box S.15a

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

No risk adjustment or risk stratification

This is not applicable.

Provided in response box S.15a

1659 Influenza Immunization

No risk adjustment or risk stratification

N/A

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

No risk adjustment or risk stratification

No risk adjustment or risk stratification

Stratification

0039 Flu Vaccinations for Adults Ages 18 and Older

N/A

0041 Preventive Care and Screening: Influenza Immunization

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

0226 Influenza Immunization in the ESRD Population (Facility Level)

Not applicable.

0431 Influenza Vaccination Coverage Among Healthcare Personnel

The measure should be calculated separately for each denominator group of healthcare personnel: employees; licensed independent practitioners; and adult students/trainees and volunteers. Definitions for these groups are as follows:

(a) Employees: all persons who receive a direct paycheck from the reporting facility (i.e., on the facility's payroll).

(b) Licensed independent practitioners: physicians (MD, DO), advanced practice nurses, and physician assistants who are affiliated with the reporting facility, but are not directly employed by it (i.e., they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact. Post-residency fellows are also included in this category if they are not on the facility's payroll.

(c) Adult students/trainees and volunteers: medical, nursing, or other health professional students, interns, medical residents, or volunteers aged 18 or older who are affiliated with the healthcare facility, but are not directly employed by it (i.e., they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact.

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

This section is not applicable.

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

This is not applicable.

1659 Influenza Immunization

Measure is not stratified.

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

Type Score

0039 Flu Vaccinations for Adults Ages 18 and Older

Rate/proportion better quality = higher score

0041 Preventive Care and Screening: Influenza Immunization

Rate/proportion better quality = higher score

0226 Influenza Immunization in the ESRD Population (Facility Level)

Rate/proportion better quality = higher score

0431 Influenza Vaccination Coverage Among Healthcare Personnel

Rate/proportion better quality = higher score

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

Rate/proportion better quality = higher score

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

Rate/proportion better quality = higher score

1659 Influenza Immunization

Rate/proportion better quality = higher score

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

Rate/proportion better quality = higher score

Algorithm

0039 Flu Vaccinations for Adults Ages 18 and Older

Flu Vaccination for Adults Ages 18-64

Step 1) Identify the eligible population of Medicaid and Commercial CAHPS respondents

Step 2) Identify the denominator: Adults age 18-64 as of July 1 of the measurement year who responded "yes" or "no" to the question "Have you had either a flu shot or flu spray in the nose since July 1, YYYY?" Respondents who answer "don't know" or have a missing response are not included in the denominator.

Step 3) Identify the numerator: Adults in the denominator who answer “yes” to the question.

Step 4) Calculate the rate as numerator/denominator

Flu Vaccination for Adults Age 65 and Older

Step 1) Identify the eligible population of Medicare CAHPS respondents

Step 2) Identify the denominator: Adults age 65 as of July 1 of the measurement year who responded “yes” or “no” to the question “Have you had a flu shot or flu spray in the nose since July 1, YYYY?” Respondents who answer “don’t know” or have a missing response are not included in the denominator.

Step 3) Identify the numerator: Adults in the denominator who answer “yes” to the question.

Step 4) Calculate the rate as numerator/denominator No diagram provided

0041 Preventive Care and Screening: Influenza Immunization

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, patient allergy) patient reason(s) (eg, patient declined) or system reason(s) for the patient not receiving influenza immunization (eg, vaccine not available, other system reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. No diagram provided

0226 Influenza Immunization in the ESRD Population (Facility Level)

DENOMINATOR

Include in the denominator all patients within a facility who meet the following criteria during the time from October 1 (or when the influenza vaccine became available) to March 31 of the reporting year:

1. Diagnosis = ESRD

AND

2. Primary type of dialysis = hemodialysis, home hemodialysis, continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), or nighttime intermittent peritoneal dialysis (NIPD)

AND

3. Age = \geq 6 months or older as of the first day of the most recent month of the reporting period. (Patient's age is or shall be determined by subtracting the patient's date of birth from the first day of the most recent month of the reporting period.)

NUMERATOR

Include in the numerator all patients from the denominator who meet the following criteria:**

1. Patient received an influenza vaccination* (documented by the provider or reported receipt from another provider by the patient);

OR

2. Patient was assessed and offered an influenza vaccination but declined;

OR

3. Patient was assessed and was determined to have a medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, and/or bone marrow transplant within the past 6 months (<6 months prior to encounters between October 1 and March 31).

*Only inactivated vaccine should be used in the ESRD population.

** Each of the 3 numerator subcategories are to be computed and reported separately. No diagram provided

0431 Influenza Vaccination Coverage Among Healthcare Personnel

Among each of the denominator groups, the measure may be calculated by dividing the number of HCP in the first numerator category (i.e., received an influenza vaccination) by the number of HCP in that denominator group, and multiplying by 100 to produce a vaccination rate expressed as a percentage of all HCP in the denominator group. Rates of medical contraindications, declinations, and unknown vaccination status can be calculated similarly using the second, third, and fourth numerator categories, respectively.

As noted above, numerator categories should not be summed; each numerator status should be calculated and reported separately. Available at measure-specific web page URL identified in S.1

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

For each setting the calculation algorithm for the overall measure and submeasures a-c are:

Step 1: Identify the total number of residents or patients meeting the denominator criteria.

Step 2: For the first submeasure (NQF #0680a: Percent of Residents or Patients Who Received the Seasonal Influenza Vaccine (short stay)):

Step 2a: Identify the total number of patients or short-stay residents who received the seasonal influenza vaccine during the current or most recently completed influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]).

Step 2b: Divide the results of Step 2a by the result of Step 1.

Step 3: For the second submeasure (NQF #0680b: Percent of Residents or Patients Who Offered and Declined the Seasonal Influenza Vaccine (short stay)):

Step 3a: Identify the total number of patients or short-stay residents who were offered and declined the seasonal influenza vaccine (O0250C = [4]).

Step 3b: Divide the results of Step 3a by the result of Step 1.

Step 4: For the third submeasure (NQF #0680c: Percent of Residents or Patients Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine (short stay)):

Step 4a: Identify the total number of patients or short-stay residents who were ineligible due to medical contraindication(s) (O0250C = [3]).

Step 4b: Divide the results of Step 4a by the result of Step 1.

Step 5: For the overall measure (NQF #0680: Percent of Residents or Patients Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)):

Step 5a: Aggregate Step 2a, 3a, and 4a [Sum the total number of short-stay residents or patients who met any one of the following criteria: who received the seasonal influenza vaccine during the current or most recently completed influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]); OR who were offered and declined the seasonal influenza vaccine (O0250C = [4]); OR who were ineligible due to medical contraindication(s) (O0250C = [3]).]

Step 5b: Divide the results of Step 5a by the result of Step 1. Available at measure-specific web page URL identified in S.1

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

The calculation algorithm for the overall measure and submeasures a-c are:

Step 1: Identify the total number of residents meeting the denominator criteria.

For the first submeasure (NQF #0681a: Percent of Residents Who Received the Seasonal Influenza Vaccine (long stay)):

Step 2a: Identify the total number of long-stay residents who received the seasonal influenza vaccine during the current or most recently completed influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]).

Step 3a: Divide the results of Step 2a by the result of Step 1.

For the second submeasure (NQF #0681b: Percent of Residents Who Offered and Declined the Seasonal Influenza Vaccine (long stay)):

Step 2b: Identify the total number of long-stay residents who were offered and declined the seasonal influenza vaccine (O0250C = [4]).

Step 3b: Divide the results of Step 2b by the result of Step 1.

For the third submeasure (NQF #0681c: Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine (long stay)):

Step 2c: Identify the total number of long-stay residents who were ineligible due to medical contraindication(s) (O0250C = [3]).

Step 3c: Divide the results of Step 2c by the result of Step 1.

For the overall measure (NQF #0681: Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)):

Step 2d: Aggregate Step 2a, 2b, and 2c [Sum the total number of long-stay residents who met any of the following criteria: who received the seasonal influenza vaccine during the current or most recently completed influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]); OR who were offered and declined the seasonal influenza vaccine (O0250C = [4]); OR who were ineligible due to medical contraindication(s) (O0250C = [3]).]

Step 3d: Divide the results of Step 2d by the result of Step 1. Available at measure-specific web page URL identified in S.1

1659 Influenza Immunization

Numerator: Inpatient discharges who were screened for Influenza vaccine status and were vaccinated prior to discharge if indicated.

Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October, November, December, January, February or March.

Variable Key: Patient Age

1. Start processing. Run cases that are included in the Global Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.
2. Calculate Patient Age. Patient Age, in years, is equal to the Admission Date minus the Birthdate. Use the month and day portion of admission date and birthdate to yield the most accurate age. Only cases with valid Admission Date and Birthdate will pass the critical feedback messages into the measure specific algorithms.
3. Check Patient Age
 - a. If the Patient Age is less than 6 months old, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
 - b. If the Patient Age is greater than or equal to 6 months, continue processing and proceed to ICD-10-PCS Principal or Other Procedure Codes.
4. Check ICD-10-PCS Principal or Other Procedure Codes
 - a. If at least one of ICD-10-PCS Principal or Other Procedure Codes is on Appendix_A.Table 12.10 Organ Transplant codes.xls the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
 - b. If all of ICD-10-PCS Principal or Other Procedure Codes are missing or none of ICD-10-PCS Principal or Other Procedure Codes is on Appendix_A.Table 12.10 Organ Transplant codes.xls, continue processing and check Discharge Disposition.
5. Check Discharge Disposition
 - a. If Discharge Disposition equals 4, 6, or 7 the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
 - b. If Discharge Disposition equals 1, 2, 3, 5, or 8 continue processing and proceed to Discharge Date.
 - c. If Discharge Disposition is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
6. Check Discharge Date. Note: 'yyyy' refers to the specific year of discharge.

- a. If the Discharge Date is 04-01-yyyy through 09-30-yyyy, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
 - b. If the Discharge Date is 10-01-yyyy through 03-31-yyyy, continue processing and proceed to Influenza Vaccination Status.
 - 7. Check Influenza Vaccination Status
 - a. If Influenza Vaccination Status is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.
 - b. If Influenza Vaccination Status equals 6, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.
 - c. If Influenza Vaccination Status equals 1, 2, 3, 4, or 5, continue processing and recheck Influenza Vaccination Status.
 - 8. Recheck Influenza Vaccination Status
 - a. If Influenza Vaccination Status equals 5, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.
 - b. If Influenza Vaccination Status equals 1, 2, 3, or 4 the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing.
- Available at measure-specific web page URL identified in S.1

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.
3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator
4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, patient allergy) patient reason(s) (eg, patient declined) or system reason(s) for the patient not receiving influenza immunization (eg, vaccine not available, other system reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. No diagram provided

Submission items

0039 Flu Vaccinations for Adults Ages 18 and Older

5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

0226 : Influenza Immunization in the ESRD Population (Facility Level)

0227 : Influenza Immunization

0041 : Preventive Care and Screening: Influenza Immunization

0431 : Influenza Vaccination Coverage Among Healthcare Personnel

0522 : Influenza Immunization Received for Current Flu Season (Home Health)

1659 : Influenza Immunization

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Measure 0039 is the only measure collected through patient survey. This measure is collected through the CAHPS 5.0 Adult Survey. We specify collecting this measure through a survey because many adult flu vaccinations are given outside of the traditional medical setting (e.g. at work or in retail flu clinics) and are therefore less likely to be documented in a medical record or claim.

5b.1 If competing, why superior or rationale for additive value: NCQA views these measures as complementary to each other; each supporting the goal of protecting the individual and the population from active influenza viruses.

0041 Preventive Care and Screening: Influenza Immunization

5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

0226 : Influenza Immunization in the ESRD Population (Facility Level)

0039 : Flu Vaccinations for Adults Ages 18 and Older

0431 : Influenza Vaccination Coverage Among Healthcare Personnel

0522 : Influenza Immunization Received for Current Flu Season (Home Health)

1659 : Influenza Immunization

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Related measures have differing target populations from measure 0041 Preventive Care and Screening: Influenza Immunization. Measure #0041 is intended to evaluate adherence to the current recommendations of the Advisory Committee on Immunization Practices. The Committee recommends routine annual influenza vaccination for all persons aged ≥ 6 months who do not have contraindications. Measure #0039 - Flu Vaccinations for Adults ages 18 and Older focuses on the self-reported receipt of influenza vaccination among adults using the CAHPS survey. Measure #0226 – Influenza Immunization in the ESRD Population is a facility level measure focused on influenza vaccination among end stage renal disease (ESRD) patients

receiving hemodialysis or peritoneal dialysis. Measure #0431 - Influenza Vaccination Coverage Among Healthcare Personnel focuses on influenza vaccination among healthcare workers. Measure #0522 Influenza Immunization Received for Current Flu Season (Home Health) evaluates influenza immunization during home health episodes of care. Measure #0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay) applies to patients of Inpatient Rehabilitation Facilities and Long-Term Care Hospitals, and to short-stay nursing home residents. Measure #0681 - Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay) assess influenza vaccination among long-stay nursing facility residents. Measure #1659 Influenza Immunization is limited to the assessment of influenza vaccination upon discharge from the inpatient setting.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

0226 Influenza Immunization in the ESRD Population (Facility Level)

5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

0227 : Influenza Immunization

0039 : Flu Vaccinations for Adults Ages 18 and Older

0041 : Preventive Care and Screening: Influenza Immunization

0149 : Influenza vaccination

0432 : Influenza Vaccination of Nursing Home/ Skilled Nursing Facility Residents

0522 : Influenza Immunization Received for Current Flu Season (Home Health)

1659 : Influenza Immunization

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable.

5b.1 If competing, why superior or rationale for additive value: No known competing measures.

0431 Influenza Vaccination Coverage Among Healthcare Personnel

5.1 Identified measures:

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: An additional category was added to the numerator statement to explicitly capture "unknown" vaccination status. See Section 4d.1 for rationale.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

5.1 Identified measures: 0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

1659 : Influenza Immunization

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable.

5b.1 If competing, why superior or rationale for additive value: The current measure for Nursing Homes is expanded to both additional post-acute care settings (LTCHs and IRFs), as well as to additional data sources (MDS 3.0 remained the data source of nursing homes, IRF-PAI is the data source for IRFs, and the LTCH CARE Data Set is the data source for LTCHs). The proposed measure is harmonized to the NQF Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations.

A possible competing measure is the National Committee for Quality Assurance (NCQA) measure titled: Flu vaccinations for adults ages 65 and older: percentage of Medicare members 65 years of age and older who received an influenza vaccination between July 1 of the measurement year and the date when Medicare CAHPS survey was completed.

This NCQA measure is based on the CAHPS Health Plan Survey and targets a different and non-institutionalized population, so while this is a related measure, it does not compete with NQF #0680, which provides distinctive value.

Another possible competing measure for IRFs and LTCHs is NQF #1659 titled: Influenza Immunization for Hospital/Acute Care Facility AND Institute for Clinical Systems (ICS). The measure suggests immunizations of adult patients 18 years and older to be up to date with all immunization vaccines with follow up time periods.

NQF #1659 targets a different population in multiple settings and does not include those assessed but not given the vaccine. ICS is not NQF endorsed and has a different target population with a broader numerator (multiple other vaccines). NQF #0680 targets a different population in multiple settings, so while it is a related measure, it does not compete with NQF# 0680.

0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

1659 : Influenza Immunization

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable.

5b.1 If competing, why superior or rationale for additive value: NQF #0680 Percent of Residents or Patients Assessed and Appropriately Given the Seasonal Influenza Vaccine (SS) applies to short-stay nursing home residents as well as additional post-acute care settings (LTCHs and IRFs), and is based on different data sources for each setting (MDS 3.0 for nursing homes, IRF-PAI is the data source for IRFs, and the LTCH CARE Data Set is the data source for LTCHs). Both NQF #0680 and the current measure #0681 for long stay nursing home residents were developed together and harmonized to the NQF Voluntary Consensus Standards for Influenza Immunizations and each other as much as possible.

A possible competing measure is NQF #1659: Influenza Immunization for Hospital/Acute Care Facility AND Institute for Clinical Systems (ICS) suggest immunizations of adult patients 18 years and older, to be up to date with all immunization vaccines with follow up time periods. NQF #1659 targets a different population in a different setting and does not include those assessed but not given the vaccine. ICS is not NQF endorsed and has a different target population with a broader numerator (multiple other vaccines). NQF #0680 targets a different population in multiple settings.

Another possible competing measure is the National Committee for Quality Assurance (NCQA) measure titled: Flu vaccinations for adults ages 65 and older: percentage of Medicare members 65 years of age and older who received an influenza vaccination between July 1 of the measurement year and the date when Medicare CAHPS survey was completed.

This NCQA measure is based on the CAHPS Health Plan Survey and targets a different and non-institutionalized population, so NQF #0681 offers distinctive value.

1659 Influenza Immunization

5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

0226 : Influenza Immunization in the ESRD Population (Facility Level)

0038 : Childhood Immunization Status (CIS)

0039 : Flu Vaccinations for Adults Ages 18 and Older

0041 : Preventive Care and Screening: Influenza Immunization

0431 : Influenza Vaccination Coverage Among Healthcare Personnel

0522 : Influenza Immunization Received for Current Flu Season (Home Health)

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Measures focus on different patient populations based on age, health conditions or location (e.g., home health, physician office, short term skilled, long term stay, acute care hospital, etc.). There are some differences in Exclusions and Inclusions specific to the population. These differences are in part based upon procedures that may be performed in an acute care hospital that would not be performed in a skilled setting or physician office setting. Additionally IMM-2 excludes cases in which the vaccine has been ordered but it has not yet been received. We've found in the past that there have been some seasons in which the vaccine became available much later than expected and seasons in which there were shortages. We prefer to exclude these cases if there is documentation in the chart to support either of these scenarios

5b.1 If competing, why superior or rationale for additive value: Multiple measures are justified because they each focus on a different patient population. A single measure could not capture the variability inherent in these different populations.

IMM-2 is the only measure that focuses on patients in the acute care hospital setting.

3070 Preventive Care and Screening: Influenza Immunization (eMeasure companion to 0041)

5.1 Identified measures: 0680 : Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)

0681 : Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)

0226 : Influenza Immunization in the ESRD Population (Facility Level)

0039 : Flu Vaccinations for Adults Ages 18 and Older

0431 : Influenza Vaccination Coverage Among Healthcare Personnel

0522 : Influenza Immunization Received for Current Flu Season (Home Health)

1659 : Influenza Immunization

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Related measures have differing target populations from measure 0041 Preventive Care and Screening: Influenza Immunization. Measure #0041 is intended to evaluate adherence to the current recommendations of the Advisory Committee on Immunization Practices for all persons aged ≥ 6 months who do not have contraindications. Measure #0039 - Flu Vaccinations for Adults ages 18 and Older focuses on the self-reported receipt of influenza vaccination among adults using the CAHPS survey. Measure #0226 – Influenza Immunization in the ESRD Population is a facility level measure focused on influenza vaccination among end stage renal disease (ESRD) patients receiving hemodialysis or peritoneal dialysis. Measure #0431 - Influenza Vaccination Coverage Among Healthcare Personnel focuses on influenza vaccination among healthcare workers. Measure #0522 Influenza Immunization Received for Current Flu Season (Home Health) evaluates influenza immunization during home health episodes of care. Measure # 0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay) applies to patients of Inpatient Rehabilitation Facilities and Long-Term Care Hospitals, and to short-stay nursing home residents. Measure #0681 - Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay) assess influenza vaccination among long-stay nursing facility residents. Measure #1659 Influenza Immunization is limited to the assessment of influenza vaccination upon discharge from the inpatient setting.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

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