This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The sub-criteria and most of the footnotes from the evaluation criteria are provided in Word comments and will appear if your cursor is over the highlighted area (or in the margin if your Word program is set to show revisions in balloons). Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized): Complete all yellow highlighted areas of the form. Evaluate the extent to which each sub-criterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: If there is no TAP or workgroup, the SC also evaluates the sub-criteria (yellow highlighted areas).

Steering Committee: Complete all pink highlighted areas of the form. Review the workgroup/TAP assessment of the sub-criterion, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met
C = Completely (unquestionably demonstrated to meet the criterion)
P = Partially (demonstrated to partially meet the criterion)
M = Minimally (addressed but demonstrated to only minimally meet the criterion)
N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA = Not applicable (only an option for a few sub-criteria as indicated)

(for NQF staff use) NQF Review #: ACP-013-10 NQF Project: Ambulatory Care - Additional Outpatient Measures 2010

MEASURE DESCRIPTIVE INFORMATION

De.1 Measure Title: Otitis Media with Effusion: Systemic corticosteroids - Avoidance of inappropriate use

De.2 Brief description of measure: Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic corticosteroids

1.1-2 Type of Measure: process

De.3 If included in a composite or paired with another measure, please identify composite or paired measure

De.4 National Priority Partners Priority Area: Overuse

De.5 IOM Quality Domain: effectiveness, efficiency, equity

De.6 Consumer Care Need: Getting Better

CONDITIONS FOR CONSIDERATION BY NQF

Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:

A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.

A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)? Yes

A.2 Indicate if Proprietary Measure (as defined in measure steward agreement): agreement signed and submitted

A.3 Measure Steward Agreement: agreement signed and submitted

A.4 Measure Steward Agreement attached:

B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and
## 1. IMPORTANCE TO MEASURE AND REPORT

Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. **Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.** (evaluation criteria)

### 1a. High Impact

** Specific NPP goal:

1a.1 Demonstrated High Impact Aspect of Healthcare: affects large numbers

1a.2

1a.3 Summary of Evidence of High Impact: “About 2.2 million diagnosed episodes of OME occur annually in the United States, yielding a combined direct and indirect annual cost estimate of $4.0 billion...About 90% of children (80% of individual ears) have OME at some time before school age, most often between ages 6 months and 4 years. In the first year of life, more than 50% of children will experience OME, increasing to more than 60% by age 2 years. Many episodes resolve spontaneously within 3 months, but about 30% to 40% of children have recurrent OME and 5% to 10% of episodes last 1 year or longer.”


### 1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: OME usually resolves spontaneously with indications for therapy only if the condition is persistent and clinically significant benefits can be achieved. Systemic steroids have no proven long-term effectiveness and have potential adverse effects.
1c. Outcome or Evidence to Support Measure Focus

1c.1 Relationship to Outcomes (For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population; Systemic corticosteroids will not lead to the clinical resolution of OME. The measure aims to minimize the use of ineffective treatments.

1c.2-3. Type of Evidence: evidence based guideline

1c.4 Summary of Evidence (as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome; The prior OME guideline did not recommend oral steroids for treating OME in children. A later meta-analysis showed no benefit for oral steroid versus placebo within 2 weeks…Oral steroids can produce behavioral changes, increased appetite, and weight gain. Additional adverse effects may include adrenal suppression, fatal varicella infection, and avascular necrosis of the femoral head.

1c.5 Rating of strength/quality of evidence (also provide narrative description of the rating and by whom;

Grade A

1c.6 Method for rating evidence: Evidence quality for grades of evidence

Grade A: Well-designed randomized controlled trials or diagnostic studies performed on a population similar to the guideline’s target population

Grade B: Randomized controlled trials or diagnostic studies with minor limitations; overwhelmingly consistent evidence from observational studies

Grade C: Observational studies (case control and cohort design)

Grade D: Expert opinion, case reports, reasoning from first principles (bench research or animal studies)

Grade X: Exceptional situations where validating studies cannot be performed and there is a clear preponderance of benefit over harm

1c.7 Summary of Controversy/Contradictory Evidence:

1c.8 Citations for Evidence (other than guidelines):

1c.9 Quote the Specific guideline recommendation (including guideline number and/or page number):

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
Antimicrobials and corticosteroids do not have long-term efficacy and are not recommended for routine management. (Recommendation based on systematic review of randomized, controlled trials and preponderance of harm over benefit. [Aggregate evidence quality - Grade A]) (AAFP/AAO-HNSF/AAP)


1c.12 Rating of strength of recommendation (also provide narrative description of the rating and by whom):
Recommendation

1c.13 Method for rating strength of recommendation (If different from USPSTF system, also describe rating and how it relates to USPSTF):
Strong recommendation - A strong recommendation means the benefits of the recommended approach clearly exceed the harms (or that the harms clearly exceed the benefits in the case of a strong negative recommendation) and that the quality of the supporting evidence is excellent (Grade A or B)*. In some clearly identified circumstances, strong recommendations may be made based on lesser evidence when high-quality evidence is impossible to obtain and the anticipated benefits strongly outweigh the harms. Implication: Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.

Recommendation - A recommendation means the benefits exceed the harms (or that the harms clearly exceed the benefits in the case of a negative recommendation), but the quality of evidence is not as strong (Grade B or C)*. In some clearly identified circumstances, recommendations may be made based on lesser evidence when high-quality evidence is impossible to obtain and the anticipated benefits outweigh the harms. Implication: Clinicians should also generally follow a recommendation but should remain alert to new information and sensitive to patient preferences.

Option - An option means that either the quality of evidence that exists is suspect (Grade D)* or that well-done studies (Grade A, B, or C)* show little clear advantage to one approach versus another. Implication: Clinicians should be flexible in their decision making regarding appropriate practice, although they may set bounds on alternatives; patient preference should have a substantial influencing role.

No recommendation - No recommendation means there is both a lack of pertinent evidence (Grade D)* and an unclear balance between benefits and harms. Implication: Clinicians should feel little constraint in their decision making and be alert to new published evidence that clarifies the balance of benefit versus harm; patient preference should have a substantial influencing role.

1c.14 Rationale for using this guideline over others:
It is the PCPI policy to use guidelines, which are evidence-based, applicable to physicians and other healthcare providers, and developed by a national specialty organization or government agency. In addition, the PCPI has now expanded what is acceptable as the evidence base for measures to included documented quality improvement (QI) initiatives or implementation projects that have demonstrated improvement in the quality of care.

TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for importance to Measure and Report?

<table>
<thead>
<tr>
<th>Rationale:</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)</td>
<td>Eval Rating</td>
</tr>
</tbody>
</table>
2a. MEASURE SPECIFICATIONS

S.1 Do you have a web page where current detailed measure specifications can be obtained?
S.2 If yes, provide web page URL:

2a. Precisely Specified

<table>
<thead>
<tr>
<th>ID</th>
<th>Specification</th>
</tr>
</thead>
<tbody>
<tr>
<td>2a.1</td>
<td>Numerator Statement (Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome): Patients who were not prescribed systemic corticosteroids</td>
</tr>
<tr>
<td>2a.2</td>
<td>Numerator Time Window (The time period in which cases are eligible for inclusion in the numerator): Once within the denominator time window</td>
</tr>
<tr>
<td>2a.3</td>
<td>Numerator Details (All information required to collect/calculate the numerator, including all codes, logic, and definitions): EHR specifications for the measure are under development</td>
</tr>
</tbody>
</table>

**Claims Specifications**
- CPT Category II code: 4136F - Systemic corticosteroids not prescribed

2a.4 Denominator Statement (Brief, text description of the denominator - target population being measured):
- All patients aged 2 months through 12 years with a diagnosis of OME

2a.5 Target population gender: Female, Male

2a.6 Target population age range: Aged 2 months through 12 years

2a.7 Denominator Time Window (The time period in which cases are eligible for inclusion in the denominator):
- Each episode* of OME occurring during the twelve consecutive months
  *An episode of OME is defined as a 90-day period from onset of Otitis Media with Effusion (as indicated by the first occurrence of qualifying diagnosis and CPT codes).

2a.8 Denominator Details (All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions):
- EHR specifications for the measure are under development

**Claims Specifications**
- ICD-9-CM diagnosis codes: 381.10, 381.19, 381.20, 381.29, 381.3, 381.4
- AND
- CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99381, 99382, 99383, 99384, 99391, 99392, 99393, 99394

2a.9 Denominator Exclusions (Brief text description of exclusions from the target population):
- Documentation of medical reason(s) for prescribing systemic corticosteroids (eg, patient has a coexisting condition like rhinitis for which systemic corticosteroids are indicated)

2a.10 Denominator Exclusion Details (All information required to collect exclusions to the denominator, including all codes, logic, and definitions):
- EHR specifications for the measure are under development

**Claims Specifications**
- Documentation of medical reason(s) for prescribing systemic corticosteroids
- Append modifier to CPT Category II code: 4135F-1P

2a.11 Stratification Details/Variables (All information required to stratify the measure including the

**Comment [K9]:** 11 Risk factors that influence outcomes should not be specified as exclusions.
12 Patient preference is not a clinical exception to eligibility and can be influenced by provider interventions.
stratification variables, all codes, logic, and definitions):
Stratification by insurance coverage (commercial, Medicare and Medicaid) is recommended by some implementers.

2a.12-13 Risk Adjustment Type: no risk adjustment necessary

2a.14 Risk Adjustment Methodology/Variables (List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method):

2a.15-17 Detailed risk model available Web page URL or attachment:

2a.18-19 Type of Score: rate/proportion

2a.20 Interpretation of Score: better quality = lower score

2a.21 Calculation Algorithm (Describe the calculation of the measure as a flowchart or series of steps):
See sample calculation algorithm attached

2a.22 Describe the method for discriminating performance (e.g., significance testing):

2a.23 Sampling (Survey) Methodology If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):

2a.24 Data Source (Check the source(s) for which the measure is specified and tested)
Electronic administrative data/claims, electronic Health/Medical Record, paper medical record/flowsheet, special or unique data

2a.25 Data source/data collection instrument (Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.):

2a.26-28 Data source/data collection instrument reference web page URL or attachment:

2a.29-31 Data dictionary/code table web page URL or attachment:

2a.32-35 Level of Measurement/Analysis (Check the level(s) for which the measure is specified and tested)
Clinicians: Individual, Clinicians: Group

2a.36-37 Care Settings (Check the setting(s) for which the measure is specified and tested)
Ambulatory Care: Office, Ambulatory Care: Clinic, Ambulatory Care: Hospital Outpatient

2a.38-41 Clinical Services (Healthcare services being measured, check all that apply)
Clinicians: PA/NP/Advanced Practice Nurse, Clinicians: Physicians (MD/DO)

TESTING/ANALYSIS

2b. Reliability testing

2b.1 Data/sample (description of data/sample and size): This measure is utilized in the QuIN project sponsored Care for Children with Otitis Media with Effusion Project. This AHRQ funded study is in progress, at the Center for Health Care Quality at the Cincinnati Children’s Hospital Medical Center. Participating physicians pull 30 charts of otitis media patients with effusion and review the performance measures for feasibility, also assessing inter-rater reliability. The project will use simple frequencies and the kappa statistic as a measure of inter-rater reliability to assess feasibility and reliability of data collection.

QuINN Project Overview and Requirements. Available at:

Comment [KP10]: 2b. Reliability testing demonstrates the measure results are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period.
### 2b. Analytic Method (type of reliability & rationale, method for testing):

**2b.3 Testing Results** (reliability statistics, assessment of adequacy in the context of norms for the test conducted):

### 2c. Validity testing

**2c.1 Data/sample** (description of data/sample and size):

**2c.2 Analytic Method (type of validity & rationale, method for testing):**

It is the consensus of the PCPI Measures Implementation and Evaluation Committee that face and content validity of PCPI measures can be assumed to be established once they have progressed beyond the Public Comment period by virtue of the specialized expertise of the PCPI work group members who are involved in identifying and drafting performance measures within a topical domain as well, as the rigorous, structured discussions that are prescribed according to PCPI protocols for work group conduct.

**2c.3 Testing Results** (statistical results, assessment of adequacy in the context of norms for the test conducted):

### 2d. Exclusions Justified

**2d.1 Summary of Evidence supporting exclusion(s):**

The PCPI supports the consideration of exceptions (or exclusions) on a measure by measure basis. There must be a clear rationale to permit an exception for a medical, patient, or system reason, based on whether or not that reason is significant and occurs frequently enough. The PCPI also advocates for the systematic review and analysis of each physician’s exceptions data to identify practice patterns and opportunities for quality improvement. That is, while exceptions are removed from the denominator (risk adjustment for outcomes/resource use measures) when calculating performance, rates of exceptions should be reported alongside performance rates.

Denominator exceptions are included in this particular measure so that physicians can identify patients who have prostate cancer, inequalities in treatment outcomes of African American men including factors that are associated with differences/inequalities in care such as race, socioeconomic status, gender (e.g., poorer treatment outcomes of African American men with prostate cancer, inequalities in treatment for CVD risk factors between men and women).

**2d.2 Citations for Evidence:***

**2d.3 Data/sample** (description of data/sample and size):

**2d.4 Analytic Method (type analysis & rationale):

**2d.5 Testing Results (e.g., frequency, variability, sensitivity analyses):**

### 2e. Risk Adjustment for Outcomes/ Resource Use Measures

**2e.1 Data/sample** (description of data/sample and size):

**2e.2 Analytic Method (type of risk adjustment, analysis, & rationale):

**2e.3 Testing Results** (risk model performance metrics):

**2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:**

### 2f. Identification of Meaningful Differences in Performance

**Rating:** C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable

---

**Comment [KP12]:** 2c. Validity testing demonstrates that the measure reflects the quality of care provided, adequately distinguishing good and poor quality. If face validity is the only validity addressed, it is systematically assessed.

**Comment [KP13]:** 9 Examples of validity testing include, but are not limited to: determining if measure scores adequately distinguish between providers known to have good or poor quality assessed by another valid method; correlation of measure scores with another valid indicator of quality for the specific topic; ability of measure scores to predict scores on some other related valid measure; content validity for multi-item scales/tests. Face validity is a subjective assessment by experts of whether the measure reflects the quality of care (e.g., whether the proportion of patients with BP < 140/90 is a marker of quality). If face validity is the only validly addressed, it is systematically assessed.

**Comment [KP14]:** 2d. Clinically necessary measure exclusions are identified and must be:

- supported by evidence of sufficient frequency of occurrence so that results are distorted without the exclusion;
- AND

**Comment [KP15]:** 10 Examples of evidence that an exclusion distorts measure results include, but are not limited to: frequency of occurrence, sensitivity analyses with and without the exclusion, and variability of exclusions across providers.

**Comment [KP16]:** 2e. For outcome measures and other measures (e.g., resource use) when indicated:

- an evidence-based risk-adjustment strategy (e.g., risk models, risk-stratification) is specified and is based on patient clinical factors that influence the measured outcome.

**Comment [KP17]:** 13 Risk models should not obscure disparities in care for populations by including factors that are associated with differences/inequalities in care such as race, socioeconomic status, gender (e.g., poorer treatment outcomes of African American men with prostate cancer, inequalities in treatment for CVD risk factors between men and women).

**Comment [KP18]:** 2f. Data analysis demonstrates that methods for scoring and analysis of the specified measure allow for identification of statistically significant and practically/clinically meaningful differences in performance.
### 2f.1 Data/sample from Testing or Current Use (description of data/sample and size):

#### 2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance (type of analysis & rationale):

#### 2f.3 Provide Measure Scores from Testing or Current Use (description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance):

<table>
<thead>
<tr>
<th>Rating</th>
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<th>N</th>
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</table>

### 2g. Comparability of Multiple Data Sources/Methods

#### 2g.1 Data/sample (description of data/sample and size):

#### 2g.2 Analytic Method (type of analysis & rationale):

#### 2g.3 Testing Results (e.g., correlation statistics, comparison of rankings):

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</table>

### 2h. Disparities in Care

#### 2h.1 If measure is stratified, provide stratified results (scores by stratified categories/cohorts):

#### 2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:

The PCPI and NCQA are currently developing a framework for stratifying measures to test for disparities.

TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for **Scientific Acceptability of Measure Properties?**

<table>
<thead>
<tr>
<th>Rating</th>
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</table>

### 3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)

<table>
<thead>
<tr>
<th>Rating</th>
<th>C</th>
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<th>M</th>
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</table>

### 3a. Meaningful, Understandable, and Useful Information

#### 3a.1 Current Use: testing not yet completed

#### 3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large) (If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years):

This measure is used in the CMS PQRI program claims option for 2008 and 2009, and registry option for 2009.

#### 3a.3 If used in other programs/initiatives (If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years):

We are currently conducting a project utilizing this measure, "Cost Savings from Avoidance of Inappropriate Use: An Application of Acute Otitis Externa/Otitis Media w/ Effusion Measures"

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

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</table>

Comment [K19]: 14 With large enough sample sizes, small differences that are statistically significant may or may not be practically or clinically meaningful. The substantive question may be, for example, whether a statistically significant difference of one percentage point in the percentage of patients who received smoking cessation counseling (e.g., 74% v. 75%) is clinically meaningful; or whether a statistically significant difference of $25 in cost for an episode of care (e.g., $5,000 v. $5,025) is practically meaningful. Measures with overall poor performance may not demonstrate much variability across providers.

Comment [KP20]: 2g. If multiple data sources/methods are allowed, there is demonstration they produce comparable results.

Comment [KP21]: 2h. If disparities in care have been identified, measure specifications, scoring, and analysis allow for identification of disparities through stratification of results (e.g., by race, ethnicity, socioeconomic status, gender) OR rationale/data justifies why stratification is not necessary or not feasible.

Comment [KP22]: 3a. Demonstration that information produced by the measure is meaningful, understandable, and useful to the intended audience(s) for both public reporting (e.g., focus group, cognitive testing) and informing quality improvement (e.g., quality improvement initiatives). An important outcome that may not have an identified improvement strategy still can be useful for informing quality improvement by identifying the need for and stimulating new approaches to improvement.
3a.4 Data/sample (description of data/sample and size):

3a.5 Methods (e.g., focus group, survey, QI project):

3a.6 Results (qualitative and/or quantitative results and conclusions):

3b/3c. Relation to other NQF-endorsed measures

3b.1 NQF # and Title of similar or related measures:

(for NQF staff use) Notes on similar/related endorsed or submitted measures:

3b. Harmonization
If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population-setting/data source or different topic but same target population):

3b.2 Are the measure specifications harmonized? If not, why?

3c. Distinctive or Additive Value

3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:

5.1 Competing Measures If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), describe why it is a more valid or efficient way to measure quality:

TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for Usability?

Steering Committee: Overall, to what extent was the criterion, Usability, met?

Rationale:

4. FEASIBILITY
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)

4a. Data Generated as a Byproduct of Care Processes

4a.1-2 How are the data elements that are needed to compute measure scores generated?

data generated as byproduct of care processes during delivery, coding/abstraction performed by someone other than person obtaining original information,

4b. Electronic Sources

4b.1 Are all the data elements available electronically? (elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims) Yes

4b.2 If not, specify the near-term path to achieve electronic capture by most providers.

4c. Exclusions

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
### 4c. Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?

**4c.1** Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?

No

**4c.2** If yes, provide justification.

### 4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences

**4d.1** Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.

Physicians have voluntarily reported on this measure as part of the PQRI program. We are not aware of any unintended consequences related to this measurement.

### 4e. Data Collection Strategy/Implementation

**4e.1** Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/implementation issues:

**4e.2** Costs to implement the measure (*costs of data collection, fees associated with proprietary measures*):

**4e.3** Evidence for costs:

**4e.4** Business case documentation:

### 4f. TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for Feasibility?

Steering Committee: Overall, to what extent was the criterion, *Feasibility*, met?

**Rationale:**

### RECOMMENDATION

*(for NQF staff use)* Check if measure is untested and only eligible for time-limited endorsement.

Steering Committee: Do you recommend for endorsement?

**Comments:**

### CONTACT INFORMATION

**Co.1 Measure Steward (Intellectual Property Owner)**

**Co.1 Organization**

American Medical Association | 515 N State St. | Chicago | Illinois | 60654

**Co.2 Point of Contact**

Mark Antman, DDS, MBA | mark.antman@ama-assn.org | 312-464-5056

**Co.3 Measure Developer If different from Measure Steward**

**Co.3 Organization**

American Medical Association | 515 N State St. | Chicago | Illinois | 60654
Co.4 **Point of Contact**
Mark | Antman, DDS, MBA | mark.antman@ama-assn.org | 312-464-5056

Co.5 **Submitter If different from Measure Steward POC**
Mark | Antman, DDS, MBA | mark.antman@ama-assn.org | 312-464-5056- | American Medical Association

Co.6 **Additional organizations that sponsored/participated in measure development**
American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS) Foundation

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**ADDITIONAL INFORMATION**

**Workgroup/Expert Panel involved in measure development**

Ad.1 **Provide a list of sponsoring organizations and workgroup/panel members’ names and organizations.**

Describe the members’ role in measure development.

- **Allan S. Lieberthal, MD, FAAP** (Co-Chair) (pediatrics)
- **Richard M. Rosenfeld, MD, MPH** (Co-Chair) (otolaryngology)
- **Brian L. Bachelder, MD** (family medicine)
- **Steve I. Pelton, MD** (pediatrics/pediatric infectious diseases)
- **Karen Jo Doyle, MD, PhD** (otolaryngology)
- **Peter S. Roland, MD** (otolaryngology)
- **Cynthia P. Helstad, PhD, RN**
- **Xavier Sevilla, MD** (pediatrics)
- **Rahul Khare, MD, FACEP** (emergency medicine)
- **David L. Witsell, MD, MHS** (otolaryngology)

PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study must be equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

Ad.2 **If adapted, provide name of original measure:**

Ad.3-5 **If adapted, provide original specifications URL or attachment**

**Measure Developer/Steward Updates and Ongoing Maintenance**

Ad.6 **Year the measure was first released:** 2007

Ad.7 **Month and Year of most recent revision:**

Ad.8 **What is your frequency for review/update of this measure?**

Every 3 years or as new evidence becomes available that materially affects the measures

Ad.9 **When is the next scheduled review/update for this measure?** 2010-03

Ad.10 **Copyright statement/disclaimers:**

These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.

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Additional Information web page URL or attachment: Attachment Sample Calculation Algorithm-634007179256034523.doc

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1c. The measure focus is:

• an outcome (e.g., morbidity, mortality, function, health-related quality of life) that is relevant to, or associated with, a national health goal/priority, the condition, population, and/or care being addressed; OR

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

4 Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multi-step process, the step with the greatest effect on the desired outcome should be selected as the focus of measurement. For example, although assessment of immunization status and recommending immunization are necessary steps, they are not sufficient to achieve the desired impact on health status - patients must be vaccinated to achieve immunity. This does not preclude consideration of measures of preventive screening interventions where there is a strong link with desired outcomes (e.g., mammography) or measures for multiple care processes that affect a single outcome.

2d. Clinically necessary measure exclusions are identified and must be:

• supported by evidence of sufficient frequency of occurrence so that results are distorted without the exclusion; AND

• a clinically appropriate exception (e.g., contraindication) to eligibility for the measure focus; AND

• precisely defined and specified:
  - if there is substantial variability in exclusions across providers, the measure is specified so that exclusions are computable and the effect on the measure is transparent (i.e., impact clearly delineated, such as number of cases excluded, exclusion rates by type of exclusion);

if patient preference (e.g., informed decision-making) is a basis for exclusion, there must be evidence that it strongly impacts performance on the measure and the measure must be specified so that the information about patient preference and the effect on the measure is transparent (e.g., numerator category computed separately, denominator exclusion category computed separately).

2e. For outcome measures and other measures (e.g., resource use) when indicated:

• an evidence-based risk-adjustment strategy (e.g., risk models, risk stratification) is specified and is based on patient clinical factors that influence the measured outcome (but not disparities in care) and are present at start of care; OR rationale/data support no risk adjustment.

13 Risk models should not obscure disparities in care for populations by including factors that are associated with differences/inequalities in care such as race, socioeconomic status, gender (e.g., poorer treatment outcomes of women).
Sample PCPI Calculation Algorithm

**Calculation for Performance**
For performance purposes, a measure is calculated by creating a fraction with the following components: Numerator, Denominator, and Denominator Exclusions.

**Numerator (A) Includes:**
Number of patients meeting numerator criteria

**Denominator (PD) Includes:**
Number of patients meeting criteria for denominator inclusion

**Denominator Exclusions (C) Include:**
Number of patients with valid medical, patient or system exclusions (where applicable; will differ by measure)

**Performance Calculation**

\[
\frac{A}{PD - C}
\]

Where:
- \(A\) is the number of patients meeting numerator criteria
- \(PD\) is the number of patients in the denominator
- \(C\) is the number of patients with valid denominator exclusions

If a measure does not allow for exclusion(s), it is calculated by creating a fraction with the following components: Numerator and Denominator.

**Numerator (A) Includes:**
Number of patients meeting numerator criteria

**Denominator (PD) Includes:**
Number of patients meeting criteria for denominator inclusion

**Overall Exclusion Calculation**

\[
\frac{C}{PD}
\]

Where:
- \(C\) is the number of patients with any valid exclusion
- \(PD\) is the number of patients in the denominator

**Exclusion Calculation by Type**

\[
\frac{C_1}{PD} \quad \frac{C_2}{PD} \quad \frac{C_3}{PD}
\]

Where:
- \(C_1\) is the number of patients with medical reason
- \(C_2\) is the number of patients with patient reason
- \(C_3\) is the number of patients with system reason