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)

<table>
<thead>
<tr>
<th>Measure Title: Endoscopy/Polyp Surveillance: Comprehensive Colonoscopy Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>De.2 Brief description of measure: Percentage of final colonoscopy reports for patients aged 18 years and older that include documentation of all of the following: pre-procedure risk assessment; depth of insertion; quality of the bowel prep; complete description of polyp(s) found, including location of each polyp, size, number and gross morphology; and recommendations for follow-up</td>
</tr>
<tr>
<td>1.1-2 Type of Measure: process</td>
</tr>
<tr>
<td>De.3 If included in a composite or paired with another measure, please identify composite or paired measure</td>
</tr>
<tr>
<td>De.4 National Priority Partners Priority Area: population health</td>
</tr>
<tr>
<td>De.5 IOM Quality Domain: patient-centered, effectiveness, safety, timeliness</td>
</tr>
<tr>
<td>De.6 Consumer Care Need: Staying Healthy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONDITIONS FOR CONSIDERATION BY NQF</th>
<th>NQF Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>A</td>
</tr>
<tr>
<td>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)?</td>
<td>Y</td>
</tr>
<tr>
<td>A.2 Indicate if Proprietary Measure (as defined in measure steward agreement):</td>
<td>Y</td>
</tr>
<tr>
<td>A.3 Measure Steward Agreement: agreement signed and submitted</td>
<td>Y</td>
</tr>
<tr>
<td>A.4 Measure Steward Agreement attached:</td>
<td>Y</td>
</tr>
</tbody>
</table>

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
### TAP/Workgroup Reviewer Name:

**Steering Committee Reviewer Name:**

#### 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.**

1a. High Impact

(for NQF staff use) Specific NPP goal:

<table>
<thead>
<tr>
<th>1a.1 Demonstrated High Impact Aspect of Healthcare: frequently performed procedure, high resource use, patient/societal consequences of poor quality, affects large numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a.2 Summary of Evidence of High Impact: Colonoscopy is an importance means of preventing and treating colorectal cancer, the second leading cause of death in the U.S. and a leading cause of death in Medicare beneficiaries. Incomplete colonoscopy reports that are missing the recommended elements have been documented in the published literature. As a result, patients may not be given an accurate diagnosis, which may lead to missed diagnoses or repeat exams in shorter time frames. Performing colonoscopy too often not only increases patients’ exposure to procedural harm, but also drains resources that could be more effectively used to adequately screen those in need (Lieberman et al, 2009).</td>
</tr>
</tbody>
</table>

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: The goal of this measure is to ensure that a quality colonoscopy is completed including the patient's risk, findings, and recommendations. A fully comprehensive colonoscopy will help to better identify patients at risk and will minimize unnecessary follow-up. The use of this measure will contribute to the overall effectiveness of the

**Comment [KP1]:** 1a. The measure focus addresses:

- a specific national health goal/priority identified by NQF’s National Priorities Partners; OR
- a demonstrated high impact aspect of healthcare (e.g., affects large numbers, leading cause of morbidity/mortality, high resource use (current and/or future), severity of illness, and patient/societal consequences of poor quality).

**Comment [KP2]:** 1b. Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating considerable variation, or overall poor performance, in the quality of care across providers and/or population groups (disparities in care).
colonoscopy, which influences the timing of repeat examinations, and reduces inappropriate colonoscopies and costs.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
Several studies have demonstrated significant gaps in the quality of colonoscopies, showing that colonoscopy reports often do not include the recommended components.
1. The Clinical Outcomes Research Initiative (CORI) on Colonoscopy Quality Indicators Study of 53 gastroenterology practice sites in 24 states looked at all patients undergoing colonoscopy (n=438,521); in this study, documentation of risk assessment was measured. The ASA Classification field was not completed in 10.1% of reports. In 10 of 53 sites, completion rates were less than 90%. When completed, 7.0% of exams were performed in high-risk individuals with ASA class 3 or higher (Lieberman et al, 2009).
2. Numerous studies have shown that physicians routinely do not document the depth of insertion in the colonoscopy report. Quality evaluation of the colon consists of intubation of the entire colon and a detailed mucosal inspection. Cecal intubation improves sensitivity and reduces costs by eliminating the need for radiographic procedures or repeat colonoscopy to complete examination. Careful mucosal inspection is essential to effective colorectal cancer prevention and reduction of cancer mortality.
3. The Clinical Outcomes Research Initiative (CORI) on Colonoscopy Quality Indicators Study of 53 gastroenterology practice sites in 24 states looked at all patients undergoing colonoscopy (n=438,521); in this study, quality of bowel prep recorded was assessed. Findings indicated that 13.9% of reports did not have bowel prep quality reported and in 14 of 53 practices, over 20% did not have bowel prep quality (Lieberman et al, 2009).
4. A recent multi-center study looked at variations in practice and assessed the quality of colonoscopy procedures. Findings indicated that polyp size not recorded in 4.9% of polyps, polyp morphology (pedunculated, sessile, flat) was not reported in 14.7% of reported polyps, and polyp retrieval and submission to pathology was not documented in 4.5% of polyps (Lieberman et al, 2009). These gaps in the documentation of the description of the polyps removed during colonoscopy underscore the need to improve physician adherence to quality patient care.
5. Recent evidence suggests that surveillance colonoscopy for post-polypectomy patients in the United States is frequently performed at intervals that are shorter than those recommended in guidelines. In addition, many patient records do not have a recommended follow-up interval recorded. For example, in a 2006 study of 1282 colonoscopy reports, recommendations were consistent with contemporaneous guidelines in only 39.2% of cases and with current guidelines in 36.7% of cases. Correspondence from the endoscopist included no guidance on follow-up testing in 33.5% of cases (Krist et al, 2007).

1b.3 Citations for data on performance gap:


1b.4 Summary of data on disparities by population group:
At this time, we have not found any published literature/data on disparities by population group

1b.5 Citations for data on Disparities:
N/a
to ensure appropriate documentation of colonoscopy findings and recommendations, in order to improve physician adherence to quality patient care and decrease overuse of resources. Pre-procedure risk assessment is often used as a surrogate of co-morbidity; research has shown an association between higher class and adverse events. The need for cecal intubation is based on the continual finding that a substantial number of colorectal neoplasms are located in the proximal colon, including the cecum. Poor bowel preparation is a major impediment to the effectiveness of colonoscopy and impacts the ability to detect polyps and influences the timing of repeat examinations. Poor preparation prolongs cecal intubation time and withdrawal time and reduces detection of both small and large polyps (Faigel et al, 2006). The economic burden of repeating examinations because of inadequate bowel preparation is substantial. Accurate polyp descriptions are essential to assess disease progression and inform timing of repeat colonoscopy.

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):

Before sedation is begun, a risk assessment is performed to stratify patients into higher or lower-risk-for-complications groups (particularly as pertains to sedation) [Grade 1C] (Faigel et al, 2006). The physician/nurse team should document the risk assessment. (Risk stratification systems commonly used are the ASA score and the Mallampati score). Visualization of the cecum by notation of landmarks and photo documentation of landmarks should be documented in every procedure (Grade 1C). Most important, these include the appendiceal orifice and the ileocecal valve. There should be documentation in the procedure note of the quality of the preparation of the bowel (Grade 2C) (Faigel et al, 2006). In clinical trials of bowel preparation, terms used to commonly characterize bowel preparation include “excellent,” “good,” “fair,” and “poor.” In clinical practice, these terms do not have standardized definitions. In clinical trials on the effectiveness of various regimens for bowel preparation, excellent is typically defined as no or minimal solid stool and only small amounts of clear fluid requiring suctioning. “Good” is typically no or minimal solid stool with large amounts of clear fluid requiring suctioning. “Fair” refers to collections of semisolid debris that are cleared with difficulty. “Poor” refers to solid or semisolid debris that cannot be effectively cleared. The endoscopist should be prepared to perform a total examination and remove all polyps found at the time of the first colonoscopy, although technical factors encountered during colonoscopy may limit completion of the procedure (Davila et al, 2006).

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

<table>
<thead>
<tr>
<th>1 C, 2C</th>
</tr>
</thead>
</table>

1c.6 Method for rating evidence: Grade of Recommendation: 1C

Clarity of Benefit: Clear
Methodologic strength/Supporting evidence: Observational studies
Implications: Intermediate-strength recommendation; may change when stronger evidence is available

Grade of Recommendation: 2C
Clarity of Benefit: Unclear
Methodologic strength/Supporting evidence: Observational studies
Implications: Very weak recommendation; alternative approaches likely to be better under some circumstances

1c.7 Summary of Controversy/Contradictory Evidence: n/a

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

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

Before sedation is begun, a risk assessment is performed to stratify patients into higher or lower-risk-for-complications groups (particularly as pertains to sedation) [Grade 1C] (Faigel et al, 2006). The physician/nurse team should document the risk assessment. (Risk stratification systems commonly used are the ASA score and the Mallampati score). Visualization of the cecum by notation of landmarks and photo documentation of landmarks should be documented in every procedure (Grade 1C). Most important, these

Comment [k6]: The strength of the body of evidence for the specific measure focus should be systematically assessed and rated (e.g., USPSTF grading system http://www.ahrq.gov/clinic/uspsdif7/methods/benefit.htm). If the USPSTF grading system was not used, the grading system is explained including how it relates to the USPSTF grades or why it does not. However, evidence is not limited to quantitative studies and the best type of evidence depends upon the question being studied (e.g., randomized controlled trials appropriate for studying drug efficacy are not well suited for complex system changes). When qualitative studies are used, appropriate qualitative research criteria are used to judge the strength of the evidence.
include the appendiceal orifice and the ileocecal valve. There should be documentation in the procedure note of the quality of the preparation of the bowel (Grade 2C) (Faigel et al, 2006). In clinical trials of bowel preparation, terms used to commonly characterize bowel preparation include “excellent,” “good,” “fair,” and “poor.” In clinical practice, these terms do not have standardized definitions. In clinical trials on the effectiveness of various regimens for bowel preparation, excellent is typically defined as no or minimal solid stool and only small amounts of clear fluid requiring suctioning. “Good” is typically no or minimal solid stool with large amounts of clear fluid requiring suctioning. “Fair” refers to collections of semisolid debris that are cleared with difficulty. “Poor” refers to solid or semisolid debris that cannot be effectively cleared. The endoscopist should be prepared to perform a total examination and remove all polyps found at the time of the first colonoscopy, although technical factors encountered during colonoscopy may limit completion of the procedure (Davila et al, 2006).

1c.10 Clinical Practice Guideline Citation: Davila, R, Rajan, E, Baron, T. American Society for Gastrointestinal Endoscopy. ASGE guideline: colorectal cancer screening and surveillance. Vol. 63. No.4; 2006.


1c.11 National Guideline Clearinghouse or other URL: http://www.guidelines.gov/summary/summary.aspx?doc_id=10162&nbr=5347#s24

1c.12 Rating of strength of recommendation (also provide narrative description of the rating and by whom):
1C, 2C

1c.13 Method for rating strength of recommendation (If different from USPSTF system, also describe rating and how it relates to USPSTF):
1A Clarity of Benefit: Clear
Methodologic strength/supporting evidence:Randomized trials without important limitations
Implications: Strong recommendation; can be applied to most clinical settings

1B Clarity of Benefit Clear
Methodologic strength/supporting evidence Randomized trials with important limitations (inconsistent results, nonfatal methodologic flaws)
Implications: Strong recommendation; likely to apply to most practice settings

1C Clarity of Benefit: Clear
Methodologic strength/supporting evidence:Overwhelming evidence from observational studies
Implications: Strong recommendation; can apply to most practice settings in most situations

1C Clarity of Benefit: Clear
Methodologic strength/supporting evidence:Observational studies
Implications: Intermediate-strength recommendation; may change when stronger evidence is available

2A Clarity of Benefit: Unclear
Methodologic strength/supporting evidence: Randomized trials without important limitations
Implications: Intermediate-strength recommendation; best action may differ depending on circumstances or patients’ or societal values

2B Clarity of Benefit: Unclear
Methodologic strength/supporting evidence: Randomized trials with important limitations (inconsistent results, nonfatal methodologic flaws)
Implications: Weak recommendation; alternative approaches may be better under some circumstances

2C Clarity of Benefit: Unclear
Methodologic strength/supporting evidence: Observational studies

Comment [k7]: USPSTF grading system http://www.ahrq.gov/clinic/uspstf/grades.htm:
A - The USPSTF recommends the service. There is high certainty that the net benefit is substantial.
B - The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.
C - The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. Offer or provide this service only if other considerations support the offering or providing the service in an individual patient.
D - The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.
I - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.
### 2a. MEASURE SPECIFICATIONS

#### 2a.1 Numerator Statement (Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome):

Final reports that include documentation of ALL of the following:
- Pre-procedure risk assessment (e.g., ASA class, Mallampati score)
- Depth of insertion (i.e., to cecum or other landmark)
- Quality of the bowel prep (i.e., prep was either adequate or inadequate)
- Complete description of polyp(s) found, including location of each polyp, size, number and gross morphology
- Recommendations for follow-up

#### 2a.2 Numerator Time Window (The time period in which cases are eligible for inclusion in the numerator):

Every procedure within the denominator time window

#### 2a.3 Numerator Details (All information required to collect/calculate the numerator, including all codes, logic, and definitions):

EHR Specifications for this measure are under development

#### Claims Specifications:

3018F - Pre-procedure risk assessment AND depth of insertion AND quality of the bowel prep AND complete description of polyp(s) found, including location of each polyp, size, number and gross morphology AND recommendations for follow-up in final colonoscopy report, documented

---

Comment [KP8]: 2a. The measure is well defined and precisely specified so that it can be implemented consistently within and across organizations and allow for comparability. The required data elements are of high quality as defined by NQF’s Health Information Technology Expert Panel (HITEP).
| 2a.4 Denominator Statement | (Brief, text description of the denominator - target population being measured):  
All final colonoscopy reports for patients aged 18 years and older |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2a.5 Target population gender:</td>
<td>Male, Female</td>
</tr>
<tr>
<td>2a.6 Target population age range:</td>
<td>Ages 18 and over</td>
</tr>
</tbody>
</table>
| 2a.7 Denominator Time Window | (The time period in which cases are eligible for inclusion in the denominator):  
12 month period |
| 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 this measure are under development |
| 2a.9 Denominator Exclusions | (Brief text description of exclusions from the target population):  
None |
| 2a.10 Denominator Exclusion Details | (All information required to collect exclusions to the denominator, including all codes, logic, and definitions):  
N/A |
| 2a.11 Stratification Details/Variables | (All information required to stratify the measure including the stratification variables, all codes, logic, and definitions):  
Stratification by insurance coverage (Commercial, Medicare and Medicaid) is recommended by 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):  
N/A |
| 2a.18-19 Type of Score: | rate/proportion |
| 2a.20 Interpretation of Score: | better quality = higher 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): | N/A |
| 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):  
N/A |
| 2a.24 Data Source | (Check the source(s) for which the measure is specified and tested)  
paper medical record/flowsheet, Electronic administrative data/claims, electronic Health/Medical Record, 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.):  
N/A |
| 2a.26-28 Data source/data collection instrument reference web page URL or attachment: | N/A |

Comment [kb]: 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.
<table>
<thead>
<tr>
<th><strong>2a.29-31 Data dictionary/code table web page URL or attachment:</strong></th>
</tr>
</thead>
</table>

**Clinicians:** Physicians (MD/DO), Clinicians: Group

**Data dictionary/code table web page URL or attachment:**

**Testing/Analysis**

2b. Reliability testing

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

2b.2 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):

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):

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

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

**Comments**

- 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 period.
- Comment [K11]: 8 Examples of reliability testing include, but are not limited to: inter-rater/abstractor or intra-rater/abstractor studies; internal consistency for multi-item scales; test-retest for survey items. Reliability testing may address the data items or final measure score.
- 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 [K13]: 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 measures 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 validity addressed, it is systematically assessed (e.g., ratings by relevant stakeholders) and the measure is judged to represent quality care for the specific topic and that the measure focus is the most important aspect of quality for the specific topic.
- 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 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 ca) [1]
- Comment [K15]: 10 Examples of evidence that an exclusion distorts measure results include, but are not limited to: frequency of occurrence, sensitivity analyzes 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 (but not disparities in care) and are present at start of care.
<table>
<thead>
<tr>
<th>2e.1 Data/sample (description of data/sample and size):</th>
<th>P</th>
<th>M</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2e.2 Analytic Method (type of risk adjustment, analysis, &amp; rationale):</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2e.3 Testing Results (risk model performance metrics):</td>
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<tr>
<td>2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:</td>
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<tr>
<td>2f. Identification of Meaningful Differences in Performance</td>
<td></td>
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</tr>
<tr>
<td>2f.1 Data/sample from Testing or Current Use (description of data/sample and size):</td>
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<tr>
<td>2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance (type of analysis &amp; rationale):</td>
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<tr>
<td>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):</td>
<td></td>
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<tr>
<td>2g. Comparability of Multiple Data Sources/Methods</td>
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<tr>
<td>2g.1 Data/sample (description of data/sample and size):</td>
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<tr>
<td>2g.2 Analytic Method (type of analysis &amp; rationale):</td>
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<tr>
<td>2g.3 Testing Results (e.g., correlation statistics, comparison of rankings):</td>
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<tr>
<td>2h. Disparities in Care</td>
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<tr>
<td>2h.1 If measure is stratified, provide stratified results (scores by stratified categories/cohorts):</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for Scientific Acceptability of Measure Properties?</td>
<td></td>
<td></td>
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<tr>
<td>Steering Committee: Overall, to what extent was the criterion, Scientific Acceptability of Measure Properties, met?</td>
<td></td>
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</tr>
<tr>
<td>Rationale:</td>
<td></td>
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</tbody>
</table>

3. USABILITY

<table>
<thead>
<tr>
<th>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)</th>
<th>Eval Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a. Meaningful, Understandable, and Useful Information</td>
<td></td>
</tr>
<tr>
<td>3a.1 Current Use: testing not yet completed</td>
<td></td>
</tr>
<tr>
<td>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 used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s).)</td>
<td></td>
</tr>
</tbody>
</table>

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
publicly reported, state the plans to achieve public reporting within 3 years);

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);

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

4b. Electronic Sources

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Comment [KP23]: 3b. The measure specifications are harmonized with other measures, and are applicable to multiple levels and settings.

Comment [k24]: 16 Measure harmonization refers to the standardization of specifications for similar measures on the same topic (e.g., influenza immunization of patients in hospitals or nursing homes), or related measures for the same target population (e.g., eye exam and HbA1c for patients with diabetes), or definitions applicable to many measures (e.g., age designation for children) so that they are uniform or compatible, unless differences are dictated by the evidence. The dimensions of harmonization can include numerator, denominator, exclusions, and data source and collection instructions. The extent of harmonization depends on the relationship of the measures, the evidence for the specific measure focus, and differences in data sources.

Comment [KP25]: 3c. Review of existing endorsed measures and measure sets demonstrates that the measure provides a distinctive or additive value to existing NQF-endorsed measures (e.g., provides a more complete picture of quality for a particular condition or aspect of healthcare).

Comment [k26]: 5. Demonstration that the measure is superior to competing measures – new submissions and/or endorsed measures (e.g., is a more valid or efficient way to measure).

Comment [KP27]: 4a. For clinical measures, required data elements are routinely generated concurrent with and as a byproduct of care processes during care delivery. (e.g., BP recorded in the electronic record, not abstracted from the record later by other personnel; patient self-assessment tools, e.g., depression scale; lab values, meds, etc.)

Comment [KP28]: 4b. The required data elements are available in electronic sources. If the required data are not in existing electronic sources, a credible, near-term path to electronic collection by most providers is specified and clinical data elements are specified for transition to the electronic health record.
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)*

**No**

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

Electronic health record products are not uniform in ability to collect data in a standardized way at this time. Design decisions made by individual practices during the implementation of these measures can affect measure performance.

4c. Exclusions

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

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.

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:

**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**
### 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

### Measure Developer if different from Measure Steward
**Co.3 Organization**
American Medical Association | 515 N State St. | Chicago | Illinois | 60654

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

### Additional organizations that sponsored/participated in measure development
- American Society for Gastrointestinal Endoscopy (ASGE)
- American Gastroenterological Association (AGA)
- National Committee for Quality Assurance

### 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.

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.

**Co-chairs**
- John Allen, MD, MBA, AGAF (Gastroenterology)
- Doug Faigel, MD (Gastroenterology)

**Work Group Members**
- Nancy Baxter, MD, PhD, FACS, FACS (Colon and Rectal Surgery)
- Stephen Bickston, MD, AGAF (Gastroenterology)
- Joel V. Brill, MD, AGAF, FASGE, FACG, CHCQM (Gastroenterology)
- Kirk Brandon, MBA (Business Administration/Coding)
- Jason A. Dominitz, MD, MHS, AGAF (Gastroenterology)
- Ira L. Flax, MD, FACP (Gastroenterology)
- Karen E. Hall, MD, PhD (Geriatrics)
- Robert Haskey, MD, FACS (General Surgery, Health Plan representative)
- Brian C. Jacobson, MD, MPH (Gastroenterology)
- Walter Lieberman, MD (Gastroenterology)
- Klaus Mergener, MD, PhD, CPE, FACP, FACP, FASGE (Gastroenterology)
- Brett Petersen, MD, FASGE (Gastroenterology)
- Irving M. Pike, MD, FACP (Gastroenterology)
- Bart Pope, MD (Family Medicine)
- Harry Sarles, MD, FACP, FACP, FASGE, FACPE (Gastroenterology)
- Kay Schwebke, MD, MPH (Specialty: Internal Medicine, Infectious Diseases & Medical Informatics)
- Tom Lynn, MD (Medical Informatics, Methodology)
- Emily E. Volk, MD, FCAP (Pathology)
- Michael Weinstein, MD Specialty: Gastroenterology

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
### Measure Developer/Steward Updates and Ongoing Maintenance

**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: **2008**

**Ad.7** Month and Year of most recent revision: **2008-08**

**Ad.8** What is your frequency for review/update of this measure? Every 3-4 years or as new evidence becomes available that materially affects the measures

**Ad.9** When is the next scheduled review/update for this measure? **2011-08**

**Ad.10** Copyright statement/disclaimers: Physician Performance Measures (Measures) and related data specifications developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement (PCPI) and the National Committee for Quality Assurance (NCQA), pursuant to government sponsorship under Subcontract No. 6414-07-089 with Mathematica Policy Research under Contract HHSM-500-2005-000251(0004) with Centers for Medicare and Medicaid Services.

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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.
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

\[
\frac{A \text{ (# of patients meeting numerator criteria)}}{PD \text{ (# patients in denominator)} - C \text{ (# patients with valid denominator exclusions)}}
\]

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

\[
\frac{A \text{ (# of patients meeting measure criteria)}}{PD \text{ (# of patients in denominator)}}
\]

It is also possible to calculate the percentage of patients excluded overall, or excluded by medical, patient, or system reason where applicable:

Overall Exclusion Calculation

\[
\frac{C \text{ (# of patients with any valid exclusion)}}{PD \text{ (# patients in denominator)}}
\]

OR

Exclusion Calculation by Type

\[
\begin{align*}
\frac{C_1 \text{ (# patients with medical reason)}}{PD \text{ (# patients in denominator)}} & \quad \frac{C_2 \text{ (# patients with patient reason)}}{PD \text{ (# patients in denominator)}} & \quad \frac{C_3 \text{ (# patients with system reason)}}{PD \text{ (# patients in denominator)}}
\end{align*}
\]