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 subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. 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 subcriterion 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 subcriteria (yellow highlighted areas).

**Steering Committee:** Complete all pink highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, 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 subcriteria as indicated)

### Measure Descriptive Information

<table>
<thead>
<tr>
<th>Measure Title:</th>
<th>Aspirin at Arrival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description of measure:</td>
<td>Percentage of emergency department acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) without aspirin contraindications who received aspirin within 24 hours before ED arrival or prior to transfer.</td>
</tr>
</tbody>
</table>

### 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): **Y**
  - **A.3** Measure Steward Agreement: **Government entity and in the public domain - no agreement necessary**
  - **A.4** Measure Steward Agreement attached: **Y**

- **B.** The measure owner/steward verifies there is an identified responsible entity and process to maintain and

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
C. The intended use of the measure includes both public reporting and quality improvement.

**Purpose:** Public reporting, Internal quality improvement, Payment incentive

D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement.

<table>
<thead>
<tr>
<th>D.1 Testing</th>
<th>Y N</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?</td>
<td>Y N</td>
</tr>
</tbody>
</table>

(for NQF staff use) Have all conditions for consideration been met?

Staff Notes to Steward (if submission returned):

Staff Notes to Reviewers (issues or questions regarding any criteria):

**Staff Reviewer Name(s):**

---

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.**

<table>
<thead>
<tr>
<th>1a. High Impact</th>
<th>Eval Rating</th>
</tr>
</thead>
</table>

(for NQF staff use) **Specific NPP goal:**

1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, Leading cause of morbidity/mortality

1a.2


Antman EM, Anbe DT, Armstrong PW, Bates ER, Green LA, Hand M, Hochman JS, Krumholz HM,
**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): Target performance rates are 100 percent for improved outcomes.

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 early use of aspirin in patients with AMI results in a significant reduction in adverse events and subsequent mortality. The benefits of aspirin therapy on mortality are comparable to fibrinolytic therapy.

---

**Comment [K3]:** 1 Examples of data on opportunity for improvement include, but are not limited to: prior studies, epidemiologic data, measure data from pilot testing or implementation. If data are not available, the measure focus is systematically assessed (e.g., expert panel rating) and judged to be a quality problem.

**Comment [K4]:** 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:
  - Evidence that the measure is significantly associated with desired outcomes. This evidence may be observational or experimental, and may include data from prior studies, epidemiologic studies, or clinical trials.
  - Evidence that the intervention is effective and cost-effective. This evidence may include data from prior studies, clinical trials, or cost-effectiveness analyses.

**Comment [K5]:** 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 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., ... [1].

1c.6 Method for rating evidence: ABC Scale


1c.9 Quote the Specific guideline recommendation (including guideline number and/or page number): “In a dose of 162 mg or more, aspirin produces a rapid clinical antithrombotic effect caused by immediate and near-total inhibition of thromboxane A2 production. Aspirin now forms part of the early management of all patients with suspected STEMI and should be given promptly, and certainly within the first 24 hours, at a dose between 162 and 325 mg and continued indefinitely at a daily dose of 75 to 162 mg.” Page 597


1c.11 National Guideline Clearinghouse or other URL: N/A

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

A ABC Scale ACC/AHA

1c.13 Method for rating strength of recommendation (if different from USPSTF system, also describe rating and how it relates to USPSTF):

ABC Scale

• Level A (randomized controlled trial/ meta-analysis):
  High quality randomized controlled trial that considers all important outcomes. High-quality meta-analysis (quantitative systematic review) using comprehensive search strategies.
- **Level B (other evidence):**
  A well-designed, nonrandomized clinical trial. A nonquantitative systematic review with appropriate search strategies and well-substantiated conclusions. Includes lower quality randomized controlled trials, clinical cohort studies, and case-controlled studies with nonbiased selection of study participants and consistent findings. Other evidence, such as high-quality, historical, uncontrolled studies, or well-designed epidemiologic studies with compelling findings, is also included.
- **Level C (consensus/expert opinion):**
  Consensus viewpoint or expert opinion. Expert opinion is sometimes the best evidence available.

**1c.14 Rationale for using this guideline over others:**
ACC/AHA Strength of Evidence and Meta Analysis.

**TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for Importance to Measure and Report?**

<table>
<thead>
<tr>
<th>Rationale:</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

**2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES**
Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)

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

**2a. MEASURE SPECIFICATIONS**

<table>
<thead>
<tr>
<th>Do you have a web page where current detailed measure specifications can be obtained?</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

**2a. Precisely Specified**

**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):**
Emergency Department AMI or Chest Pain patients (with Probable Cardiac Chest Pain) who received aspirin within 24 hours before ED arrival or prior to transfer.

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

**2a.3 Numerator Details (All information required to collect/calculate the numerator, including all codes, logic, and definitions):**
Patients with:
- An E/M Code for emergency department encounter as defined in Appendix A, Table 1.0, and
- Patients discharged/transferred to a short term general hospital for inpatient care, or to a Federal healthcare facility, and
- An ICD-9-CM Principal Diagnosis Code for AMI as defined in Appendix A, OP Table 1.1 or an ICD-9-CM Principal or Other Diagnosis Codes for Angina, Acute Coronary Syndrome, or Chest Pain as defined in Appendix A, OP Table 1.1a with Probable Cardiac Chest Pain and
- Patients with Aspirin Received

**2a.4 Denominator Statement (Brief, text description of the denominator - target population being measured):**
Emergency Department AMI or Chest Pain patients (with Probable Cardiac Chest Pain) without aspirin contraindications.

**2a.5 Target population gender:** Female, Male

**2a.6 Target population age range:** 18 years of age and older

**2a.7 Denominator Time Window (The time period in which cases are eligible for inclusion in the denominator):**

**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).
During the measurement period.

2a.8 **Denominator Details** *(All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions):

- Patients with:
  - An E/M Code for emergency department encounter as defined in Appendix A, Table 1.0, and
  - Patients discharged/transferred to a short term general hospital for inpatient care, or to a Federal healthcare facility, and
  - An ICD-9-CM Principal Diagnosis Code for AMI as defined in Appendix A, OP Table 1.1 or an ICD-9-CM Principal or Other Diagnosis Codes for Angina, Acute Coronary Syndrome, or Chest Pain as defined in Appendix A, OP Table 1.1a with Probable Cardiac Chest Pain

2a.9 **Denominator Exclusions** *(Brief text description of exclusions from the target population): Excluded Populations:

- Patients less than 18 years of age
- Patients with a documented Reason for No Aspirin on Arrival

2a.10 **Denominator Exclusion Details** *(All information required to collect exclusions to the denominator, including all codes, logic, and definitions):


2a.11 **Stratification Details/Variables** *(All information required to stratify the measure including the stratification variables, all codes, logic, and definitions):


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.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 = Higher score

2a.21 **Calculation Algorithm** *(Describe the calculation of the measure as a flowchart or series of steps):


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)):

**Sampling Approaches**

As previously stated in this section, hospitals have the option to sample from their population, or submit their entire population. Hospitals that choose to sample must ensure that the sampled data represent their outpatient population by using either the simple random sampling or systematic random sampling method and that the sampling techniques are applied consistently within a quarter. For example, quarterly samples for a sampling population must use consistent sampling techniques across the quarterly submission period.

- Simple random sampling - selecting a sample size (n) from a population of size (N) in such a way that every case has the same chance of being selected.
- Systematic random sampling - selecting every kth record from a population of size (N) in such a way that a sample size of n is obtained, where k = N/n rounded to the lower digit. The first sample record (i.e., the starting point) must be randomly selected before taking every kth record. This is a two-step process:
a) Randomly select the starting point by choosing a number between one and k using a table of random numbers or a computer-generated random number; and
b) Then select every kth record thereafter until the selection of the sample size is completed.

Each hospital is ultimately responsible that the sampling techniques applied for their hospital adhere to the sampling requirements outlined in this manual. Performance measurement systems are responsible for ensuring that the sampling techniques are applied consistently across their client hospitals.

Monthly Sampling Guidelines

It is important to point out that if a hospital elects to use the monthly sampling guidelines, the hospital is still required to meet the minimum quarterly sampling requirements. A hospital may choose to use a larger sample size than is required. Hospitals whose population size is less than the minimum number of cases per quarter for the measure set cannot sample (i.e., the entire population of cases must be selected). Given the potential for substantial variation in monthly population sizes, the monthly sample sizes should be based on the known or anticipated quarterly population size. When necessary, appropriate oversampling should be employed to ensure that the hospital meets the minimum quarterly sample size requirements. Refer to Table 3 below for guidelines in determining the number of cases that need to be sampled for each population per month per hospital based on the quarterly population size.

Table 3: Sample Size Guidelines per Month per Hospital

<table>
<thead>
<tr>
<th>Population per Quarter</th>
<th>Monthly Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>= 80</td>
<td>use all cases</td>
</tr>
<tr>
<td>81-100</td>
<td>27</td>
</tr>
<tr>
<td>101-125</td>
<td>32</td>
</tr>
<tr>
<td>126-150</td>
<td>37</td>
</tr>
<tr>
<td>151-175</td>
<td>41</td>
</tr>
<tr>
<td>176-200</td>
<td>44</td>
</tr>
<tr>
<td>201-225</td>
<td>48</td>
</tr>
<tr>
<td>226-250</td>
<td>51</td>
</tr>
<tr>
<td>251-275</td>
<td>54</td>
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<tr>
<td>276-300</td>
<td>57</td>
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<tr>
<td>301-325</td>
<td>59</td>
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<tr>
<td>326-350</td>
<td>62</td>
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<tr>
<td>351-375</td>
<td>64</td>
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<td>376-400</td>
<td>66</td>
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<td>401-425</td>
<td>68</td>
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<td>426-450</td>
<td>70</td>
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<td>451-500</td>
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<td>501-550</td>
<td>79</td>
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<td>551-600</td>
<td>83</td>
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<td>601-700</td>
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<td>701-800</td>
<td>90</td>
</tr>
<tr>
<td>801-900</td>
<td>93</td>
</tr>
<tr>
<td>901-1,000</td>
<td>92</td>
</tr>
<tr>
<td>1,001-2,000</td>
<td>108</td>
</tr>
<tr>
<td>2,001-3,000</td>
<td>114</td>
</tr>
<tr>
<td>3,001-4,000</td>
<td>117</td>
</tr>
<tr>
<td>4,001-5,000</td>
<td>119</td>
</tr>
<tr>
<td>5,001-10,000</td>
<td>124</td>
</tr>
<tr>
<td>10,001-20,000</td>
<td>126</td>
</tr>
</tbody>
</table>

2a.24 Data Source (Check the source(s) for which the measure is specified and tested)
Paper medical record/flow-sheet, Electronic administrative data/claims, Electronic Health/Medical Record

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:

2a.29-31 Data dictionary/code table web page URL or attachment: URL
http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FFPage%2FQnetTier2&cid=1196289981244

2a.32-35 Level of Measurement/Analysis (Check the level(s) for which the measure is specified and tested)
Facility/Agency, Population: national

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

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

<table>
<thead>
<tr>
<th>TEST/ANALYSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2b. Reliability testing</td>
</tr>
<tr>
<td>2b.1 Data/sample (description of data/sample and size): Currently undergoing validation through the CMS Clinical Data Abstraction Center.</td>
</tr>
<tr>
<td>2b.2 Analytic Method (type of reliability &amp; rationale, method for testing): N/A</td>
</tr>
<tr>
<td>2b.3 Testing Results (reliability statistics, assessment of adequacy in the context of norms for the test conducted): N/A</td>
</tr>
<tr>
<td>2c. Validity testing</td>
</tr>
<tr>
<td>2c.1 Data/sample (description of data/sample and size): Currently undergoing validation through the CMS Clinical Data Abstraction Center</td>
</tr>
<tr>
<td>2c.2 Analytic Method (type of validity &amp; rationale, method for testing): N/A</td>
</tr>
<tr>
<td>2c.3 Testing Results (statistical results, assessment of adequacy in the context of norms for the test conducted): N/A</td>
</tr>
</tbody>
</table>

2d. Exclusions Justified

2d.1 Summary of Evidence supporting exclusion(s): N/A

2d.2 Citations for Evidence: N/A

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

2d.4 Analytic Method (type analysis & rationale): N/A

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

2e. Risk Adjustment for Outcomes/ Resource Use Measures

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

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

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
### 2e.3 Testing Results (risk model performance metrics):
N/A

### 2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:
N/A

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

#### 2f.1 Data/sample from Testing or Current Use (description of data/sample and size):
N/A

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

#### 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):

Q1 2010 Analysis Provider Level
2,571 hospitals submitted 40,564 eligible cases.
Min Rate 0
Max Rate 100
10th percentile 84.62
25th percentile 94.12
Median 100
75th percentile 100
90th percentile 100

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

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

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

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

### 2h. Disparities in Care

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

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

---

**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.

**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.

---

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

**Steering Committee:** Overall, to what extent was the criterion, Scientific Acceptability of Measure Properties, met?

**Rationale:**

### 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>3a. Meaningful, Understandable, and Useful Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a.1 Current Use: In use</td>
</tr>
</tbody>
</table>
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):

CMS Hospital Outpatient Department Quality Data Reporting Program
http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1191255879384

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 publicly reported, state the plans to achieve use for QI within 3 years):

N/A

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): N/A

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

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

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

3b.1 NQF # and Title of similar or related measures:
NQF # 132 Aspirin at Arrival for Acute Myocardial Infarction (AMI)

(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?
Yes

3c. Distinctive or Additive Value

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

5.1 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:
Measure is applicable to the Outpatient setting.

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria 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?

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

Comment [KP24]: 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, is a more valid or efficient way to measure).

Comment [KP26]: 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.)
### 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)

- **No**

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

NQF #132 is currently undergoing electronic retooling. It is expected the retooling will be applicable to NQF measure 286.

### 4c. Exclusions

**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.**

Updates to data elements to provide clarification in abstraction and updates to selected references.

### 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:**

Updates to data elements to provide clarification in abstraction and updates to selected references.

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

- **N/A**

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

- **N/A**

**4e.4 Business case documentation: N/A**

### TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria 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:

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

<table>
<thead>
<tr>
<th>Co.1</th>
<th>Measure Steward (Intellectual Property Owner)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co.1</td>
<td>Organization</td>
</tr>
<tr>
<td></td>
<td>Centers for Medicare &amp; Medicaid Services, 7500 Security Boulevard, Mail Stop S3-01-02, Baltimore, Maryland, 21244-1850</td>
</tr>
<tr>
<td>Co.2</td>
<td>Point of Contact</td>
</tr>
<tr>
<td></td>
<td>Wanda, Govan-Jenkins, MS, MBA, RN, <a href="mailto:Wanda.Govan-Jenkins@CMS.hhs.gov">Wanda.Govan-Jenkins@CMS.hhs.gov</a>, 410-786-2699-</td>
</tr>
<tr>
<td>Co.3</td>
<td>Measure Developer If different from Measure Steward</td>
</tr>
<tr>
<td></td>
<td>Organization</td>
</tr>
<tr>
<td></td>
<td>Oklahoma Foundation for Medical Quality, 14000 Quail Springs Parkway, Suite 400, Oklahoma City, Oklahoma, 73134-2600</td>
</tr>
<tr>
<td>Co.4</td>
<td>Point of Contact</td>
</tr>
<tr>
<td></td>
<td>Wanda, Govan-Jenkins, MS, MBA, RN, <a href="mailto:Wanda.Govan-Jenkins@CMS.hhs.gov">Wanda.Govan-Jenkins@CMS.hhs.gov</a>, 410-786-2699-</td>
</tr>
<tr>
<td>Co.5</td>
<td>Submitter If different from Measure Steward POC</td>
</tr>
<tr>
<td></td>
<td>Rebecca, Jones, MSN, RN, <a href="mailto:rjones@ofmq.com">rjones@ofmq.com</a>, 405-840-2891-342, Oklahoma Foundation for Medical Quality</td>
</tr>
<tr>
<td>Co.6</td>
<td>Additional organizations that sponsored/participated in measure development</td>
</tr>
</tbody>
</table>

## 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. |
|      | N/A |
| Ad.2 | If adapted, provide name of original measure: N/A |
| 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: 07, 2010 |
| Ad.8 | What is your frequency for review/update of this measure? Bi-annual |
| Ad.9 | When is the next scheduled review/update for this measure? 01, 2011 |
| Ad.10 | Copyright statement/disclaimers: N/A |
| Ad.11-13 | Additional Information web page URL or attachment: URL |
|      | http://qualitynet.org/dcs/ContentServer?c=Page&pagemenu=QnetPublic%2FPage%2FQualityNetTier2&cid=1196289981244 |

Date of Submission (MM/DD/YY): 12/07/2010
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.

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

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;
- rationale/data support no risk adjustment.

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). It is preferable to stratify measures by race and socioeconomic status rather than adjusting out differences.