

NATIONAL QUALITY FORUM

Measure Submission and Evaluation Worksheet 5.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the [submitting standards web page](#).

NQF #: 0041	NQF Project: Population Health: Prevention Project
(for Endorsement Maintenance Review)	
Original Endorsement Date: Aug 10, 2009 Most Recent Endorsement Date: Aug 10, 2009	
BRIEF MEASURE INFORMATION	
De.1 Measure Title: Influenza Immunization	
Co.1.1 Measure Steward: American Medical Association - Physician Consortium for Performance Improvement	
De.2 Brief Description of Measure: Percentage of patients aged 6 months and older seen for a visit between October 1 and the end of February who received an influenza immunization OR patient reported previous receipt of an influenza immunization	
2a1.1 Numerator Statement: Patients who received an influenza immunization OR who reported previous receipt* of influenza immunization	
*Previous receipt can include: receipt of influenza immunization from another provider OR receipt of influenza immunization from same provider during a visit prior to October 1	
2a1.4 Denominator Statement: All patients aged 6 months and older seen for a visit between October 1 and the end of February	
2a1.8 Denominator Exclusions: Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reason) Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reason) Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reason)	
1.1 Measure Type: Process	
2a1. 25-26 Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records	
2a1.33 Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team	
1.2-1.4 Is this measure paired with another measure? No	
De.3 If included in a composite, please identify the composite measure (<i>title and NQF number if endorsed</i>):	

STAFF NOTES (<i>issues or questions regarding any criteria</i>)
Comments on Conditions for Consideration:
Is the measure untested? Yes <input type="checkbox"/> No <input type="checkbox"/> If untested, explain how it meets criteria for consideration for time-limited endorsement:
1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (<i>check De.5</i>):
5. Similar/related endorsed or submitted measures (<i>check 5.1</i>):
Other Criteria:
Staff Reviewer Name(s):

1. IMPACT, OPPORTUNITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT

Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See [guidance on evidence](#).

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: H M L I

(The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.)

De.4 Subject/Topic Areas (Check all the areas that apply): [Prevention, Prevention : Immunization](#)

De.5 Cross Cutting Areas (Check all the areas that apply): [Population Health](#)

1a.1 Demonstrated High Impact Aspect of Healthcare: [Affects large numbers, A leading cause of morbidity/mortality](#)

1a.2 If "Other," please describe:

1a.3 Summary of Evidence of High Impact (Provide epidemiologic or resource use data):

[In the United States, annual epidemics of influenza occur typically during the late fall through early spring. Influenza viruses can cause disease among persons in any age group, but rates of infection are highest among children \(1–3\). During these annual epidemics, rates of serious illness and death are highest among persons aged >=65 years, children aged <2 years, and persons of any age who have medical conditions that place them at increased risk for complications from influenza \(1,4,5\). Influenza epidemics were associated with estimated annual averages of approximately 36,000 deaths during 1990–1999 and approximately 226,000 hospitalizations during 1979–2001 \(6,7\).](#)

1a.4 Citations for Evidence of High Impact cited in 1a.3: [Centers for Disease Control and Prevention \(CDC\). Prevention and control of influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices \(ACIP\), 2010. MMWR 2010;59\(No. RR-8\):1-62.](#)

Citing:

- [1.Monto AS, Kioumeh F. The Tecumseh study of respiratory illness. IX. Occurrence of influenza in the community, 1966–1971. Am J Epidemiol 1975;102:553–63.](#)
- [2. Glezen PF, Couch RB. Interpandemic influenza in the Houston area, 1974–76. N Engl J Med 1978;298:587–92.](#)
- [3. Glezen WP, Greenberg SB, Atmar RL, et al. Impact of respiratory virus infections on persons with chronic underlying conditions. JAMA 2000;283:499–505.](#)
- [4. Barker WH. Excess pneumonia and influenza associated hospitalization during influenza epidemics in the United States, 1970–78. Am J Public Health 1986;76:761–5.](#)
- [5. Barker WH, Mullooly JP. Impact of epidemic type A influenza in a defined adult population. Am J Epidemiol 1980;112:798–811.](#)
- [6. Thompson WW, Shay DK, Weintraub E, et al. Mortality associated with influenza and respiratory syncytial virus in the United States. JAMA 2003;289:179–86.](#)
- [7. Thompson WW, Shay DK, Weintraub E, et al. Influenza-associated hospitalizations in the United States. JAMA 2004;292:1333–40.](#)

1b. Opportunity for Improvement: H M L I

(There is a demonstrated performance gap - variability or overall less than optimal performance)

1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:

[This measure is intended to promote annual influenza vaccination for all patients aged 6 months and older, thereby reducing the likelihood of patients contracting the disease and associated morbidity and mortality.](#)

1b.2 Summary of Data Demonstrating Performance Gap (Variation or overall less than optimal performance across providers):

[For Maintenance – Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.]

[2009 data from the National Health Interview Survey conducted by the National Center for Health Statistics indicates significant opportunity for improvement:](#)

- [• 33% of children 2-17 years received an influenza vaccination during the past 12 months](#)
- [• 23% of adults 18-49 years received an influenza vaccination during the past 12 months](#)

NQF #0041 Influenza Immunization

- 41% of adults 50-64 years received an influenza vaccination during the past 12 months
- 67% of adults 65 years and over received an influenza vaccination during the past 12 months(1)

The previous version of the adult influenza immunization measure was used in the CMS Physician Quality Reporting Initiative from 2008-2010 and is currently used in the 2011 program. The measure (PQRI #110) was included in the claims option (2008, 2009, 2010) as well as the Registry and Measure Group options (2008, 2009, 2010). For the 2011 program, the measure is included in all of the available options: Claims, Registry, EHR, Measures Group, Group Practice Reporting Option I and II.

There is a gap in care as shown by the 2008 data for the adult influenza measure; 76.03 % of patients reported on did not receive the optimal care. (2)

10th percentile: 0.62%
25th percentile: 3.82%
50th percentile: 16.00%
75th percentile: 35.49%
90th percentile: 60.14%

The CKD and ESRD influenza measures focusing on a subset of patients included in the adult influenza immunization measure (and for which reliability testing data is provided) were used in the CMS Physician Quality Reporting Initiative. CKD influenza measure (PQRI #135) was included in the claims option (2009, 2010) as well as the Registry and Measure Group options (2009, 2010). The ESRD influenza measure (PQRI #79) was included in the PQRI Claims option (2008, 2009, 2010) as well as the Registry option (2009, 2010).

There is a gap in care as shown by the 2008 data for ESRD influenza measure; 70.6 % of patients reported on did not receive the optimal care. (2)

10th percentile: 0.0 %
25th percentile: 2.2 %
50th percentile: 16.7 %
75th percentile: 38.3 %
90th percentile: 66.4 %

In the 2009 data for PQRI, the CKD influenza measure #135, displayed that 51.65 % of patients reported on did not receive the optimal care. For the ESRD influenza measure #79, 39.16 % of patients reported on did not receive the optimal care.(3)

1b.3 Citations for Data on Performance Gap: [*For Maintenance* – Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included]

(1) National Center for Health Statistics. Health, United States, 2010: With Special Feature on Death and Dying. Hyattsville, MD. 2011.

(2) Confidential CMS PQRI 2008 Performance Information by Measure. Jan-Sept TAP file.

(3) CMS PQRI 2009 Quality-Data Code Submission Error Report by Measure. Jan-June TAP file.

1b.4 Summary of Data on Disparities by Population Group: [*For Maintenance* – Descriptive statistics for performance results for this measure by population group]

The CDC conducted an analysis of data from the 2002–2010 Behavioral Risk Factor Surveillance System (BRFSS) questionnaire and the National 2009 H1N1 Flu Survey (NHFS) to examine racial/ethnic disparities in influenza vaccination coverage. "Among all persons aged ≥ 6 months, combined seasonal or H1N1 influenza vaccination coverage was higher among non-Hispanic whites (49.5%) compared with non-Hispanic blacks (40.5%) and Hispanics (43.5%) ($p < 0.05$ for both). For children aged 6 months–17 years, combined coverage was lower among blacks (49.4%) compared with whites (53.8%), and higher among Hispanics (61.2%) and other non-Hispanic persons (63.5%) compared with whites ($p < 0.05$ for both). Among adults aged 18–49 years with high-risk conditions, no statistically significant differences by race/ethnicity were observed for combined seasonal or H1N1 influenza vaccination. For adults aged 50–64 years, non-Hispanic blacks (44.5%) and Hispanics (46.2%) had significantly lower combined seasonal or H1N1 influenza vaccination coverage, compared with non-Hispanic whites (49.8%). Similarly, for adults aged ≥ 65 years, non-Hispanic blacks (58.3%) and Hispanics (61.4%) had significantly lower combined seasonal or H1N1 influenza vaccination coverage compared with non-Hispanic whites (73.9) ($p < 0.05$ for each). Racial/ethnic differences in seasonal (only) influenza vaccination coverage were similar to combined seasonal or H1N1 influenza vaccination coverage estimates except

among adults aged 18–49 years with high-risk conditions, for whom seasonal (only) influenza vaccination coverage was higher among non-Hispanic whites (39.9%) than among non-Hispanic blacks (34.8%)."

1b.5 Citations for Data on Disparities Cited in 1b.4: [*For Maintenance – Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]

Setse RW, Euler GL, Gonzalez-Feliciano AG, Bryan LN, Furlow C, Weinbaum CM, Singleton JA; Centers for Disease Control and Prevention (CDC). Influenza vaccination coverage - United States, 2000-2010. *MMWR Surveill Summ.* 2011 Jan 14;60 Suppl:38-41.

1c. Evidence (*Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.*)
 Is the measure focus a health outcome? Yes No **If not a health outcome, rate the body of evidence.**

Quantity: H M L I Quality: H M L I Consistency: H M L I

Quantity	Quality	Consistency	Does the measure pass subcriterion1c?
M-H	M-H	M-H	Yes <input type="checkbox"/>
L	M-H	M	Yes <input type="checkbox"/> IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise No <input type="checkbox"/>
M-H	L	M-H	Yes <input type="checkbox"/> IF potential benefits to patients clearly outweigh potential harms: otherwise No <input type="checkbox"/>
L-M-H	L-M-H	L	No <input type="checkbox"/>

Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service

Does the measure pass subcriterion1c?
 Yes IF rationale supports relationship

1c.1 Structure-Process-Outcome Relationship (*Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome*):

Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Influenza viruses cause disease among persons in all age groups. Rates of infection are highest among children, but the risks for complications, hospitalizations, and deaths from seasonal influenza are higher among adults aged >=65 years, children aged <5 years, and persons of any age who have medical conditions that place them at increased risk for complications from influenza.

Centers for Disease Control and Prevention. Prevention and control of influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP), 2010. *MMWR* 2010;59(No. RR-8):1-62.

1c.2-3 Type of Evidence (*Check all that apply*):

Observational study, Evidence-based guideline, Systematic synthesis of research

1c.4 Directness of Evidence to the Specified Measure (*State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population*):

There is increased evidence that influenza has substantial adverse impacts in all age groups and an expectation that a simplified age-based influenza vaccine recommendation for all age groups will improve vaccine coverage levels. Published, peer-reviewed studies are the primary source of data used by ACIP in making recommendations for the prevention and control of influenza, but unpublished data that are relevant to issues under discussion also are considered. Among studies discussed or cited, those of greatest scientific quality and those that measure influenza-specific outcomes are the most influential.

Centers for Disease Control and Prevention. Prevention and control of influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP), 2010. *MMWR* 2010;59(No. RR-8):1-62.

1c.5 Quantity of Studies in the Body of Evidence (*Total number of studies, not articles*): The description of the evidence review within the guideline, did not address the overall quantity of studies in the body of evidence. However, close to 500 studies are cited in the reference section.

1c.6 Quality of Body of Evidence (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events*): The description of the evidence review within the guideline, did not address the overall quality of the body of evidence related to this measure nor was any grade provided for the quality of the body of evidence. Therefore, the following text has been included to describe the study design/flaws, directness of the evidence to the measure, and any imprecision within the studies as described by the guideline developers.

Published, peer-reviewed studies are the primary source of data used by ACIP in making recommendations for the prevention and control of influenza, but unpublished data that are relevant to issues under discussion also are considered. Among studies discussed or cited, those of greatest scientific quality and those that measure influenza-specific outcomes are the most influential. For example, population-based estimates of influenza disease burden supported by laboratory-confirmed influenza virus infection outcomes contribute the most specific data. The best evidence for vaccine or antiviral efficacy comes from randomized controlled trials that assess laboratory-confirmed influenza infections as an outcome measure and consider factors such as timing and intensity of influenza viruses' circulation and degree of match between vaccine strains and wild circulating strains. However, randomized controlled trials cannot be performed ethically in populations for which vaccination already is recommended, and in this context, observational studies that assess outcomes associated with laboratory-confirmed influenza infection also can provide important vaccine or antiviral safety and effectiveness data.

Centers for Disease Control and Prevention. Prevention and control of influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP), 2010. MMWR 2010;59(No. RR-8):1-62.

1c.7 Consistency of Results across Studies (*Summarize the consistency of the magnitude and direction of the effect*): Although there is no explicit statement regarding the overall consistency of results across studies in the guideline, the recent ACIP influenza immunization recommendations represent an expansion of the previous recommendations for annual vaccination of all adults aged 19–49 years and "is supported by evidence that annual influenza vaccination is a safe and effective preventive health action with potential benefit in all age groups."

Centers for Disease Control and Prevention. Prevention and control of influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP), 2010. MMWR 2010;59(No. RR-8):1-62.

1c.8 Net Benefit (*Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms*):

Annual influenza vaccination is a safe and effective preventive health action with potential benefit in all age groups.

...[E]vidence from clinical trials suggests that protection against viruses that are similar antigenically to those contained in the vaccine extends for at least 6–8 months.

Influenza viruses cause disease among persons in all age groups. Rates of infection are highest among children, but the risks for complications, hospitalizations, and deaths from seasonal influenza are higher among adults aged ≥65 years, children aged <5 years, and persons of any age who have medical conditions that place them at increased risk for complications from influenza.

Centers for Disease Control and Prevention. Prevention and control of influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP), 2010. MMWR 2010;59(No. RR-8):1-62.

1c.9 Grading of Strength/Quality of the Body of Evidence. Has the body of evidence been graded? No

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: Although the body of evidence was not graded, the guidelines were developed by CDC's Advisory Committee on Immunization Practices (ACIP) who provides annual recommendations for the prevention and control of influenza. The ACIP Influenza Work Group (the Work Group)* meets every 2–4 weeks throughout the year to discuss newly published studies, review current guidelines, and consider revisions to the recommendations. As the Work Group reviews the annual recommendations for consideration by the full ACIP, its members discuss a variety of issues, including the burden of influenza

illness; vaccine effectiveness, vaccine safety, and coverage in groups recommended for vaccination; feasibility; cost-effectiveness; and anticipated vaccine supply. Work Group members also request periodic updates on vaccine and antiviral production, supply, safety, and efficacy from vaccinologists, epidemiologists, and manufacturers. State and local vaccination program representatives are consulted. CDC's Influenza Division (available at <http://www.cdc.gov/flu>) provides influenza surveillance and antiviral resistance data. The Vaccines and Related Biological Products Advisory Committee provides advice on vaccine strain selection to the Food and Drug Administration (FDA), which selects the viral strains to be used in the annual trivalent influenza vaccines.

*The Work Group composition was as follows:

Chair: Kathleen Neuzil, MD, Seattle, Washington.

Members: Terry Adirim, MD, District of Columbia; William Atkinson, MD, Atlanta, Georgia; Carol Baker, MD, Houston, Texas; Beth Bell, MD, Atlanta, Georgia; Nancy Bennett, MD, Rochester, New York; Henry Bernstein, DO, Lebanon, New Hampshire; Joseph Bresee, MD, Atlanta, Georgia; Carolyn Bridges, MD, Atlanta, Georgia; Karen Broder, MD, Atlanta, Georgia; Doug Campos-Outcalt, MD, Phoenix, Arizona; Fred Cassels, MD, Rockville, Maryland; Lance Chilton, MD, Albuquerque, New Mexico; David Cho, MD, District of Columbia; Nancy Cox, PhD, Atlanta, Georgia; Therese Cvetkovich, MD, Rockville, Maryland; Sandra Dos Santos Chaves, MD, Atlanta, Georgia; Jeff Duchin, MD, Seattle, Washington; Janet Englund, MD, Seattle, Washington; Anthony Fiore, MD, Atlanta, Georgia; Sandra Fryhofer, MD, Atlanta, Georgia; Stanley Gall, MD, Louisville, Kentucky; Paul Gargiullo, PhD, Atlanta, Georgia; Steven Gordon, MD, Cleveland, Ohio; Wayne Hachey, DO, Falls Church, Virginia; John Iskander, MD, Atlanta GA; Wendy Keitel, MD, Houston, Texas; Elyse Olshen Kharbanda, MD, New York, NY; David Lakey, MD, Austin, Texas; Susan Lett, MD, Boston, Massachusetts; Tamara Lewis, MD, Salt Lake City, Utah; Cynthia Nolletti, MD, Rockville, Maryland; Gregory Poland, MD, Rochester, Minnesota; William Schaffner, MD, Nashville, Tennessee; Robert Schechter, MD, Sacramento, California; Kenneth Schmader, MD, Durham, NC; David Shay, MD, Atlanta, Georgia; Nadine Sicard, MD, Ottawa, Canada; Danuta Skowronski, MD, Vancouver, British Columbia, Canada; Patricia Stinchfield, St. Paul, Minnesota; Ray Strikas, MD, District of Columbia; Litjen Tan, PhD, Chicago, Illinois; Mary Vernon-Smiley, MD Atlanta, Georgia; Timothy Uyeki, MD, Atlanta, Georgia; Amanda Zongrone, Atlanta, Georgia.

1c.11 System Used for Grading the Body of Evidence: Published, peer-reviewed studies are the primary source of data used by ACIP in making recommendations for the prevention and control of influenza, but unpublished data that are relevant to issues under discussion also are considered. Among studies discussed or cited, those of greatest scientific quality and those that measure influenza-specific outcomes are the most influential. For example, population-based estimates of influenza disease burden supported by laboratory-confirmed influenza virus infection outcomes contribute the most specific data. The best evidence for vaccine or antiviral efficacy comes from randomized controlled trials that assess laboratory-confirmed influenza infections as an outcome measure and consider factors such as timing and intensity of influenza viruses' circulation and degree of match between vaccine strains and wild circulating strains. However, randomized controlled trials cannot be performed ethically in populations for which vaccination already is recommended, and in this context, observational studies that assess outcomes associated with laboratory-confirmed influenza infection also can provide important vaccine or antiviral safety and effectiveness data. Evidence for vaccine or antiviral safety also is provided by randomized controlled studies; however, the number of subjects in these studies often is inadequate to detect associations between vaccine and rare adverse events. The best way to assess the frequency of rare adverse events after vaccination is by controlled studies after vaccines are used widely in the population.

1c.12 If other, identify and describe the grading scale with definitions:

1c.13 Grade Assigned to the Body of Evidence: Not rated

1c.14 Summary of Controversy/Contradictory Evidence:

1c.15 Citations for Evidence other than Guidelines(*Guidelines addressed below*):
Not applicable.

1c.16 Quote verbatim, the specific guideline recommendation (*Including guideline # and/or page #*):
Routine annual influenza vaccination is recommended for all persons aged ≥ 6 months. To permit time for production of protective antibody levels, vaccination should optimally occur before onset of influenza activity in the community, and providers should offer vaccination as soon as vaccine is available. Vaccination also should continue to be offered throughout the influenza season.

(CDC ACIP, p. 1)

1c.17 Clinical Practice Guideline Citation: [Centers for Disease Control and Prevention \(CDC\). Prevention and control of influenza with vaccines. Recommendations of the Advisory Committee on Immunization Practices \(ACIP\), 2011. MMWR 2011;60\(Early Release\).](#)

1c.18 National Guideline Clearinghouse or other URL: <http://www.cdc.gov/flu/professionals/acip/>

1c.19 Grading of Strength of Guideline Recommendation. Has the recommendation been graded? **No**

1c.20 If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:

1c.21 System Used for Grading the Strength of Guideline Recommendation: **Not applicable**

1c.22 If other, identify and describe the grading scale with definitions:

1c.23 Grade Assigned to the Recommendation: **Not rated**

1c.24 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.](#)

Based on the NQF descriptions for rating the evidence, what was the developer's assessment of the quantity, quality, and consistency of the body of evidence?

1c.25 Quantity: **Moderate** 1c.26 Quality: **Moderate** 1c.27 Consistency: **Moderate**

Was the threshold criterion, *Importance to Measure and Report*, met?
(1a & 1b must be rated moderate or high and 1c yes) Yes No

Provide rationale based on specific subcriteria:

For a new measure if the Committee votes NO, then STOP.

For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.

2. RELIABILITY & VALIDITY - 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)**

Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See [guidance on measure testing](#).

S.1 Measure Web Page (In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained). Do you have a web page where current detailed specifications for this measure can be obtained? **Yes**

S.2 If yes, provide web page URL: <http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI>

2a. RELIABILITY. Precise Specifications and Reliability Testing: H M L I

2a1. Precise Measure Specifications. (The measure specifications precise and unambiguous.)

2a1.1 Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome):

Patients who received an influenza immunization OR who reported previous receipt* of influenza immunization

*Previous receipt can include: receipt of influenza immunization from another provider OR receipt of influenza immunization from same provider during a visit prior to October 1

2a1.2 Numerator Time Window *(The time period in which the target process, condition, event, or outcome is eligible for inclusion):*
Once during the measurement period

2a1.3 Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, codes with descriptors, and/or specific data collection items/responses):*
For Electronic Health Record specifications - See attached for PCPI eSpecification
For Claims/Administrative specifications -

- Report CPT Category II Code 4274F: Influenza immunization administered or previously received

OR

- CPT Procedure Code for Influenza Immunization:
- 90655, 90656, 90657, 90658
- 90660, 90661, 90662, 90663, 90664
- 90666, 90667, 90668

2a1.4 Denominator Statement *(Brief, narrative description of the target population being measured):*
All patients aged 6 months and older seen for a visit between October 1 and the end of February

2a1.5 Target Population Category *(Check all the populations for which the measure is specified and tested if any):* Adult/Elderly Care, Children's Health

2a1.6 Denominator Time Window *(The time period in which cases are eligible for inclusion):*
12 consecutive months (October prior to the start of the measurement period, and the end of February of the measurement period if using a calendar year for the 12-month measurement period)

2a1.7 Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses):*

For Electronic Health Record specifications - See attached for PCPI eSpecification

For Claims/Administrative:

Patients aged 6 months and older

AND

CPT code:

One outpatient visit between October 1 and the end of February

(October prior to the start of the measurement period, and the end of February of the measurement period if using a calendar year for the 12-month measurement period)

- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99241, 99242, 99243, 99244, 99245
- 99304, 99305, 99306, 99307, 99308, 99309, 99310
- 99315, 99316
- 99324, 99325, 99326, 99327, 99328
- 99334, 99335, 99336, 99337
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

OR

One dialysis visit between October 1 and the end of February

- 90935, 90937, 90940
- 90945, 90947

- 90951, 90952, 90953
- 90954, 90955, 90956
- 90957, 90958, 90959
- 90960, 90961, 90962
- 90963, 90964, 90965, 90966
- 90967, 90968, 90969, 90970
- 90989, 90993, 90997, 90999

OR

One preventive care visit between October 1 and the end of February

- 99381, 99382, 99383, 99384, 99385, 99386, 99387
- 99391, 99392, 99393, 99394, 99395, 99396, 99397
- 99401, 99402, 99403, 99404
- 99411, 99412

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population):*

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

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

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

2a1.9 Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses):*

For Electronic Health Record specifications - See attached for PCPI eSpecification

For Claims/Administrative specifications,

For Claims/Administrative:

Append modifier to CPT Category II code: 4274F-1P

Append modifier to CPT Category II code: 4274F-2P

Append modifier to CPT Category II code: 4274F-3P

2a1.10 Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses):*

We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

2a1.11 Risk Adjustment Type *(Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13):* No risk adjustment or risk stratification **2a1.12 If "Other," please describe:**

2a1.13 Statistical Risk Model and Variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.):*

For Electronic Health Record specifications - exceptions for this measure are outlined in the attached PCPI eSpecification

For Claims/Administrative specifications, exceptions for this measure are listed above, in section 2a.9.

2a1.14-16 Detailed Risk Model Available at Web page URL (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL. Please supply login/password if needed:

2a1.17-18. **Type of Score:** [Rate/proportion](#)

2a1.19 **Interpretation of Score** (*Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score*): [Better quality = Higher score](#)

2a1.20 **Calculation Algorithm/Measure Logic**(*Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.*):

[Calculation algorithm is included in data dictionary/code table attachment \(2a.29\).](#)

2a1.21-23 **Calculation Algorithm/Measure Logic Diagram URL or attachment:**

2a1.24 **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):

2a1.25 **Data Source** (*Check all the sources for which the measure is specified and tested*). If other, please describe: [Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records](#)

2a1.26 **Data Source/Data Collection Instrument** (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*):

2a1.27-29 **Data Source/data Collection Instrument Reference Web Page URL or Attachment:**

2a1.30-32 **Data Dictionary/Code Table Web Page URL or Attachment:**

[Attachment](#)

[AMA-PCPI_PreventiveCareScreening_Influenza_PCS-4.pdf](#)

2a1.33 **Level of Analysis** (*Check the levels of analysis for which the measure is specified and tested*): [Clinician : Group/Practice, Clinician : Individual, Clinician : Team](#)

2a1.34-35 **Care Setting** (*Check all the settings for which the measure is specified and tested*): [Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Dialysis Facility, Home Health, Other:Domiciliary, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility](#)

2a2. **Reliability Testing.** (*Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability.*)

2a2.1 **Data/Sample** (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):

- This specific updated measure has not been tested for reliability and feasibility however, testing has been done on measures with the same data elements which will be outlined in this submission. The PCPI measures for Influenza vaccination in CKD/ESRD patients are very similar to the submitted measure. The key differences between the CKD/ESRD influenza measures and the influenza measure for which this submission applies include the following age and diagnosis criteria:

- o [CKD/ESRD Measures: Patients ages 18 years and older; diagnosis of CKD stages 4, 5, not receiving RRT or diagnosis of ESRD and receiving dialysis.](#)

- o [Influenza Measure: Patients ages 6 months and older, no diagnosis required.](#)

- All testing for the CKD/ESRD measure is applicable to the more general denominator population.
- Four nephrology practice sites representing various types, locations and sizes were identified to participate in testing the measures
 - o The number of physicians per site ranged from 5-62 physicians
 - o The sites were located in four different regions: Midwestern, Western, Eastern, and Southern
 - o Patient visit volume ranged from 60-2,250 CKD patients seen per month and 240- 2,800 ESRD patients seen per month
- Sample size per physician organization ranged from 24-60 (as shown below) for a total of 112 patients with Chronic Kidney Disease (CKD) and 169 ESRD patients on Peritoneal Dialysis (PD), or Hemodialysis (HD)
 - o Site 1: 24 CKD patients; 27 ESRD patients (3 PD patients, 24 HD patients)
 - o Site 2 : 29 CKD patients; 40 ESRD patients (10 PD patients, 30 HD patients)
 - o Site 3 : 29 CKD patients; 42 ESRD patients (19 PD patients, 23 HD patients)
 - o Site 4 : 30 CKD patients; 60 ESRD patients (30 PD patients, 30 HD patients)
- Sample selection: Data were collected from the medical records of the first 35 CKD patients and first 35 ESRD patients seen at each site after July 1, 2007.
- Data abstraction was completed for multiple patient visits per patient for a total of 2686 patient visits.
- Data abstraction was performed in 2008.

2a2.2 Analytic Method (*Describe method of reliability testing & rationale*):

Data abstracted from patient records were used to calculate inter-rater reliability for the measure.

Patients were randomly selected from visits for chronic kidney disease and ESRD.

Data analysis included:

- Percent agreement
- Kappa statistic to adjust for chance agreement

2a2.3 Testing Results (*Reliability statistics, assessment of adequacy in the context of norms for the test conducted*):

- The 2 influenza measures tested are highly reliable.
- CKD/ESRD Influenza Measures (N, % Agreement, Kappa (95% Confidence Interval))
 - o CKD Influenza Immunization (112, 95.6 %, 0.87 (0.7579 - 0.9809))
 - o ESRD Influenza Immunization (169, 98.2%, 0.96 (0.9212 – 1.0000))

2b. VALIDITY. Validity, Testing, including all Threats to Validity: H M L I

2b1.1 Describe how the measure specifications (*measure focus, target population, and exclusions*) are consistent with the evidence cited in support of the measure focus (*criterion 1c*) and identify any differences from the evidence:

2b2. Validity Testing. (*Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.*)

2b2.1 Data/Sample (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):

Face validity has not yet been quantitatively assessed for this measure but there are plans to do so in the near future, prior to NQF's fall 2011 preventive care steering committee meeting

2b2.2 Analytic Method (*Describe method of validity testing and rationale; if face validity, describe systematic assessment*):

All PCPI performance measures are assessed for content validity by expert work group members during the development process. Additional input on the content validity of draft measures is obtained through a 30-day public comment period and by also soliciting comments from a panel of consumer, purchaser, and patient representatives convened by the PCPI specifically for this purpose. All comments received are reviewed by the expert work group and the measures adjusted as needed. Other external review groups (eg, focus groups) may be convened if there are any remaining concerns related to the content validity of the measures.

Face validity has not yet been quantitatively assessed for this measure but there are plans to do so in the near future, prior to prior to NQF's fall 2011 preventive care steering committee meeting. Specifically, the expert work group members will be asked to empirically assess face validity of the measure. This panel consists of 33 members, with representation from the following specialties: family medicine, internal medicine, geriatric medicine, gastroenterology, general surgery, colon & rectal surgery, infectious disease, radiology, cardiology, obstetrics & gynecology, emergency medicine, preventive medicine, occupational

medicine, nursing, psychology, occupational therapy, chiropractics, dietetics, optometry.

After the measure is fully specified, the aforementioned panel will be asked to rate their agreement with the following statement:

Please rate your agreement with the following statement for each measure:

The scores obtained from the measure as specified will accurately differentiate quality across providers.

Scale 1-5, where 1=Strongly Disagree; 3=Neither Disagree nor Agree; 5=Strongly Agree

2b2.3 Testing Results (*Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment*):

The results of the expert panel rating of the validity statement will be reported as follows:

N = X; Mean rating = X

Frequency Distribution of Ratings

1- # (Strongly Disagree)

2 - #

3 - # (Neither Disagree nor Agree)

4 - #

5 - # (Strongly Agree)

POTENTIAL THREATS TO VALIDITY. (*All potential threats to validity were appropriately tested with adequate results.*)

2b3. Measure Exclusions. (*Exclusions were supported by the clinical evidence in 1c or appropriately tested with results demonstrating the need to specify them.*)

2b3.1 Data/Sample for analysis of exclusions (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):

- Four nephrology practice sites representing various types, locations and sizes were identified to participate in testing the measures
 - o The number of physicians per site ranged from 5-62 physicians
 - o The sites were located in four different regions: Midwestern, Western, Eastern, and Southern
 - o Patient visit volume ranged from 60-2,250 CKD patients seen per month and 240- 2,800 ESRD patients seen per month
- Sample size per physician organization ranged from 24-60 (as shown below) for a total of 112 patients with Chronic Kidney Disease (CKD) and 169 ESRD patients on Peritoneal Dialysis (PD), or Hemodialysis (HD)
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 - o Site 2 : 29 CKD patients; 40 ESRD patients (10 PD patients, 30 HD patients)
 - o Site 3 : 29 CKD patients; 42 ESRD patients (19 PD patients, 23 HD patients)
 - o Site 4 : 30 CKD patients; 60 ESRD patients (30 PD patients, 30 HD patients)
- Sample selection: Data were collected from the medical records of the first 35 CKD patients and first 35 ESRD patients seen at each site after July 1, 2007
 - Data abstraction was completed for multiple patient visits per patient for a total of 2686 patient visits
 - Data abstraction was performed in 2008

2b3.2 Analytic Method (*Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference*):

Exclusions included medical, patient and systemic reasons - they were analyzed for frequency and variability across providers.

2b3.3 Results (*Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses*):

The CKD influenza measure had an exception rate of 2% and the ESRD influenza measure had an exception rate of 0%.

Verbatim documentation for CKD influenza measure exclusion instances included the following:

- Patient does not take flu shot
- Patient does not want flu shot

2b4. Risk Adjustment Strategy. (For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.)

2b4.1 Data/Sample (Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):

This measure is not risk adjusted.

2b4.2 Analytic Method (Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables):

This measure is not risk adjusted.

2b4.3 Testing Results (Statistical risk model: Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata):

Not Applicable

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment: Not Applicable

2b5. Identification of Meaningful Differences in Performance. (The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.)

2b5.1 Data/Sample (Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):

PCPI Testing Project:

- Four nephrology practice sites representing various types, locations and sizes were identified to participate in testing the measures
 - o The number of physicians per site ranged from 5-62 physicians
 - o The sites were located in four different regions: Midwestern, Western, Eastern, and Southern
 - o Patient visit volume ranged from 60-2,250 CKD patients seen per month and 240- 2,800 ESRD patients seen per month
- Sample size per physician organization ranged from 24-60 (as shown below) for a total of 112 patients with Chronic Kidney Disease (CKD) and 169 ESRD patients on Peritoneal Dialysis (PD), or Hemodialysis (HD)
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 - o Site 3 : 29 CKD patients; 42 ESRD patients (19 PD patients, 23 HD patients)
 - o Site 4 : 30 CKD patients; 60 ESRD patients (30 PD patients, 30 HD patients)
- Sample selection: Data were collected from the medical records of the first 35 CKD patients and first 35 ESRD patients seen at each site after July 1, 2007
- Data abstraction was completed for multiple patient visits per patient for a total of 2686 patient visits
- Data abstraction was performed in 2008

CMS Physician Quality Reporting Initiative:

For ESRD influenza immunization, 24,684 eligible cases were reported on for the 2008 program and 25,298 for the 2009 program. For CKD influenza immunization, 9,317 eligible cases were reported in 2009, the most recent year for which data are available.^{1,2}

Confidential CMS PQRI 2008 Performance Information by Measure. Jan-Sept TAP file.
2 CMS PQRI 2009 Quality-Data Code Submission Error Report by Measure. Jan-June TAP file.

2b5.2 Analytic Method (Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance):

The inter-quartile range (IQR) was calculated, which provides a measure of the dispersion of performance.

2b5.3 Results (Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningful differences in performance):

PCPI Testing Project Results:

Score on CKD influenza measure: N = 110 Mean = 24 %
 Score on ESRD influenza measure: N = 169 Mean = 40%

CMS Physician Quality Reporting Initiative:

The tested measures were used in the CMS Physician Quality Reporting Initiative (PQRI). The CKD influenza measure was included in the claims option (2009, 2010) as well as the Registry and Measure Group options (2009, 2010). The ESRD influenza measure was included in the PQRI Claims option (2008, 2009, 2010) as well as the Registry option (2009, 2010).

There is a gap in care as shown by the 2008 data for ESRD influenza measure; 70.6 % of patients reported on did not receive the optimal care.

10th percentile: 0.0 %
 25th percentile: 2.2 %
 50th percentile: 16.7 %
 75th percentile: 38.3 %
 90th percentile: 66.4 %

The inter-quartile range (IQR) provides a measure of the dispersion of performance. The IQR is 36.1, and indicates that 50% of physicians have performance on this measure ranging from 2.2% and 38.3%. A quarter of reporting physicians have performance on this measure which is greater than 38.3%, while a quarter have performance on this measure less than 2.2%.

Confidential CMS PQRI 2008 Performance Information by Measure. Jan-Sept TAP file.

2b6. Comparability of Multiple Data Sources/Methods. (If specified for more than one data source, the various approaches result in comparable scores.)

2b6.1 Data/Sample (Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):

All four practice sites were queried to determine PQRI involvement for the 2008 PQRI program. It was determined that 2 of the 4 testing sites for the ESRD measures were also submitting information for the 2008 PQRI Program. Of the study sites, only 1 site was able to provide PQRI data for their ESRD influenza immunization measure.

The studied site consists of 8 physicians, in an Eastern geographic location, with a sample consisting of 42 ESRD patients.

2b6.2 Analytic Method (Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure):

Abstractors conducted a validation of the PQRI claims data for sites submitting PQRI data. The process began with the identification of a random sample of Medicare claims submitted containing Quality Data Codes for PQRI. The abstractors then obtained a copy of the Medicare claim from the sites and compare the information submitted on Medicare claim with patient record to determine if it matches PQRI measure specifications.

2b6.3 Testing Results (Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted):

The ESRD influenza immunization measure was compared to PQRI claims submissions for the studied site. There were 16 PQRI claims reviewed, of which 75% were verified (12 of 16).

2c. Disparities in Care: H M L I NA (If applicable, the measure specifications allow identification of disparities.)

2c.1 If measure is stratified for disparities, provide stratified results (Scores by stratified categories/cohorts): We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:

The PCPI advocates that performance measure data should, where possible, be stratified by race, ethnicity, and primary language to assess disparities and initiate subsequent quality improvement activities addressing identified disparities, consistent with recent national efforts to standardize the collection of race and ethnicity data. A 2008 NQF report endorsed 45 practices including stratification by the aforementioned variables.(1) A 2009 IOM report “recommends collection of the existing Office of Management and Budget (OMB) race and Hispanic ethnicity categories as well as more fine-grained categories of ethnicity(referred to as granular ethnicity and based on one’s ancestry) and language need (a rating of spoken English language proficiency of less than very well and one’s preferred language for health-related encounters).”(2)

References:

(1)National Quality Forum Issue Brief (No.10). Closing the Disparities Gap in Healthcare Quality with Performance Measurement and Public Reporting. Washington, DC: NQF, August 2008.

(2)Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. March 2010. AHRQ Publication No. 10-0058-EF. Agency for Healthcare Research and Quality, Rockville, MD. Available at: <http://www.ahrq.gov/research/iomracereport>. Accessed May 25, 2010.

2.1-2.3 Supplemental Testing Methodology Information:

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met? (Reliability and Validity must be rated moderate or high) Yes No
Provide rationale based on specific subcriteria:

If the Committee votes No, STOP

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)

C.1 Intended Purpose/ Use (Check all the purposes and/or uses for which the measure is intended): Professional Certification or Recognition Program, Public Reporting, Quality Improvement (Internal to the specific organization)

3.1 Current Use (Check all that apply; for any that are checked, provide the specific program information in the following questions): Public Reporting, Professional Certification or Recognition Program, Quality Improvement (Internal to the specific organization)

3a. Usefulness for Public Reporting: H M L I
(The measure is meaningful, understandable and useful for public reporting.)

3a.1. Use in Public Reporting - disclosure of performance results to the public at large (If used in a public reporting program, provide name of program(s), locations, Web page URL(s)). If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: [For Maintenance – If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.]

This measure was used in the CMS Physician Quality Reporting Initiative in 2008, 2009, and 2010 and is currently in use in PQRS 2011. The results from the 2008-2010 PQRI programs can be found on the CMS website:

http://www.cms.gov/PQRS/01_Overview.asp#TopOfPage

The PCPI believes that the reporting of participation information is a beneficial first step on a trajectory toward the public reporting of performance results, which is appropriate since the measure has been tested and the reliability of the performance data has been validated. Continued NQF endorsement will facilitate our ongoing progress toward this public reporting objective.

3a.2. Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results: The PCPI believes that the reporting of participation information is a beneficial first step on a trajectory toward the public reporting of performance results, which is appropriate since the measure has been tested and the reliability of the performance data has been validated. NQF endorsement will facilitate our ongoing progress toward this public reporting objective.

3.2 Use for other Accountability Functions (payment, certification, accreditation). If used in a public accountability program, provide name of program(s), locations, Web page URL(s): This measure may be used in a Maintenance of Certification program.

3b. Usefulness for Quality Improvement: H M L I

(The measure is meaningful, understandable and useful for quality improvement.)

3b.1. Use in QI. If used in quality improvement program, provide name of program(s), locations, Web page URL(s):

[For Maintenance – If not used for QI, indicate the reasons and describe progress toward using performance results for improvement].

All PCPI measures are suitable for use in quality improvement initiatives and are made freely available on the PCPI website and through the implementation efforts of medical specialty societies and other PCPI members. The PCPI strongly encourages the use of its measures in QI initiatives and seeks to provide information on such initiatives to PCPI members.

3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement. If usefulness was demonstrated (e.g., QI initiative), describe the data, method and results:

The PCPI believes that the use of PCPI measures in quality improvement initiatives is a beneficial way to gather scientific data with which to improve physician performance. This is appropriate since the measure has been tested and the reliability of the performance data has been validated. NQF endorsement will facilitate our ongoing progress toward this quality improvement objective.

Overall, to what extent was the criterion, Usability, met? H M L I

Provide rationale based on specific subcriteria:

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: H M L I

4a.1-2 How are the data elements needed to compute measure scores generated? (Check all that apply).

Data used in the measure are:

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition

4b. Electronic Sources: H M L I

4b.1 Are the data elements needed for the measure as specified available electronically (Elements that are needed to compute measure scores are in defined, computer-readable fields): ALL data elements in electronic health records (EHRs)

4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources:

4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences: H M L I

4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:

We are not aware of any unintended consequences related to this measurement.

4d. Data Collection Strategy/Implementation: H M L I

A.2 Please check if either of the following apply (regarding proprietary measures):

4d.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 and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues (e.g., fees for use of proprietary measures):

The collection, availability, timing and frequency, and time and cost of data abstraction posed no challenges that would warrant changes to the measure. In addition, missing data, sampling and patient confidentiality posed no significant difficulties. Challenges related to the feasibility/implementation of the ESRD and CKD influenza immunization measures were specific to the ESRD/CKD population and would not be of concern to the general influenza immunization measure, which is the focus of this submission.

Overall, to what extent was the criterion, *Feasibility*, met? H M L I

Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes No

Rationale:

If the Committee votes No, STOP.

If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

5. COMPARISON TO RELATED AND COMPETING MEASURES

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure before a final recommendation is made.

5.1 If there are related measures (either same measure focus or target population) or competing measures (both the same measure focus and same target population), list the NQF # and title of all related and/or competing measures:

0039 : Flu Shots for Adults Ages 50 and Over

0040 : Flu Shot for Older Adults

5a. Harmonization

5a.1 If this measure has EITHER the same measure focus OR the same target population as [NQF-endorsed measure\(s\)](#): Are the measure specifications completely harmonized? No

5a.2 If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden:

The Standard Specification for Immunization Measures from the National Quality Forum (NQF) was also reviewed during development, and this measure was harmonized to the extent feasible with these standard specifications. However, the NQF Standard Specifications for Immunization measures do not support the use of a system reason exclusion to account for the lack of vaccine availability. This approach does not allow clinicians a mechanism to accurately report attention to the measure when the vaccine is not available and in addition, measurement of the lack of availability of the vaccine could assist providers in identifying their vaccine needs for subsequent years. Although vaccine distribution has improved, the work group determined that clinicians must have a method to account for vaccine unavailability.

5b. Competing Measure(s)

5b.1 If this measure has both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible):

Our measure is specified at the clinician level, but measure results can be aggregated at a higher level of measurement.

We have developed and will maintain specifications for multiple data sources, including Electronic Health Records (EHRs) and Claims-Based Reporting. Our specifications for EHRs are developed in accordance with the terminology standards (eg, SNOMED, RxNorm, LOINC) named in the Meaningful Use Program (CMS EHR Incentive Program).

Our measure also incorporates a system reason exceptions which provides a mechanism to accurately report compliancy with the

measure when the vaccine is not available.

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): American Medical Association - Physician Consortium for Performance Improvement, 515 N. State Street, Chicago, Illinois, 60654

Co.2 Point of Contact: Mark S., Antman, DDS, MBA, Director, Measure Development Operations Performance Improvement, mark.antman@ama-assn.org, 312-464-5056-

Co.3 Measure Developer if different from Measure Steward: American Medical Association - Physician Consortium for Performance Improvement, 515 N. State Street, Chicago, Illinois, 60654

Co.4 Point of Contact: Samantha, Tierney, samantha.tierney@ama-assn.org, 312-464-5524-

Co.5 Submitter: Samantha, Tierney, samantha.tierney@ama-assn.org, 312-464-5524-, American Medical Association - Physician Consortium for Performance Improvement

Co.6 Additional organizations that sponsored/participated in measure development:

The measure were developed by a multi-disciplinary, cross-speciality work group representing all key stakeholders and including representation from the following specialties, most of whom were sponsored by their medical specialty society: family medicine, internal medicine, geriatric medicine, gastroenterology, general surgery, colon & rectal surgery, infectious disease, radiology, cardiology, obstetrics & gynecology, emergency medicine, preventive medicine, occupational medicine, nursing, psychology, occupational therapy, chiropractics, dietetics, optometry.

Co.7 Public Contact: Mark, Antman, DDS, MBA, mark.antman@ama-assn.org, 312-464-5056-, American Medical Association - Physician Consortium for Performance Improvement

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.

Gail M. Amundson, MD, FACP (internal medicine/geriatrics)

Joel V. Brill MD, AGAF, FASGE, FACG (gastroenterology)

Steven B. Clauser, PhD

Will Evans, DC, PhD, CHES (chiropractic)

Ellen Giarelli, EdD, RN, CRNP (nurse practitioner)

Amy L. Halverson, MD, FACS (colon & rectal surgery)

Alex Hathaway, MD, MPH, FACPM

Charles M. Helms, MD, PhD (infectious disease)

Kay Jewell, MD, ABHM (internal medicine/geriatrics)

Daniel Kivlahan, PhD (psychology)

Paul Knechtges, MD (radiology)

George M. Lange, MD, FACP (internal medicine/geriatrics)

Trudy Mallinson, PhD, OTR/L/NZROT (occupational therapy)

Elizabeth McFarland, MD (radiology)

Jacqueline W. Miller, MD, FACS (general surgery)

Adrienne Mims, MD, MPH (geriatric medicine)

Sylvia Moore PhD, RD, FADA (dietetics)

G. Timothy Petito, OD, FAAO (optometry)

Rita F. Redberg, MD, MSc, FACC (cardiology)

Barbara Resnick, PhD, CRNP (nurse practitioner)

Sam JW Romeo, MD, MBA

Carol Saffold, MD (obstetrics & gynecology)

Robert A. Schmidt, MD (radiology)
 Samina Shahabbudin, MD (emergency medicine)
 James K. Sheffield, MD (health plan representative)
 Arthur D. Snow, MD, CMD (family medicine/geriatrics)
 Richard J. Snow, DO, MPH
 Brooke Steele, MD
 Brian Svazas, MD, MPH, FACOEM, FACPM (preventive medicine)
 David J. Weber, MD, MPH (infectious disease)
 Deanna R. Willis, MD, MBA, FFAFP (family medicine)
 Charles M. Yarborough, III, MD, MPH (occupational medicine)

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 title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward: Update of previously endorsed measure - Adult Influenza Immunization

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.3 Year the measure was first released: 2001

Ad.4 Month and Year of most recent revision: 12, 2010

Ad.5 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.6 When is the next scheduled review/update for this measure? 12, 2013

Ad.7 Copyright statement: Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians.

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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