



## Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

### Brief Measure Information

**NQF #: 0027**

**Corresponding Measures:**

**De.2. Measure Title:** Medical Assistance With Smoking and Tobacco Use Cessation

**Co.1.1. Measure Steward:** National Committee for Quality Assurance

**De.3. Brief Description of Measure:** The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

**Advising Smokers and Tobacco Users to Quit:** A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.

**Discussing Cessation Medications:** A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.

**Discussing Cessation Strategies:** A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

**1b.1. Developer Rationale:** Tobacco smoking is the leading cause of preventable disease and death in the United States, resulting in approximately 480,000 premature deaths and more than \$300 billion in direct health care expenditures and productivity losses each year (HHS, 2014). Premature deaths due to smoking, including deaths from lung cancer, pulmonary diseases, coronary heart disease, pregnancy concerns, and residential fires, numbered over 20 million between 1965 and 2014 (HHS, 2014). Although the consumption of cigarettes continues to decline (with a decrease from 20.9 percent in 2005 to 16.8 percent in 2014 (Centers for Disease Control and Prevention, 2015)), the use of electronic cigarettes, or e-cigarettes, has more than doubled between 2011 and 2012, especially among adolescents (HHS, 2014).

The strongest evidence on increasing smoking cessation comes from studies involving physician or nurse's advice, tailored self-help materials, or telephone counseling (Siu, 2015). For example, interventions that involve physician or nurse advice are associated with smoking abstinence at six months or more after the intervention (8.0 percent for physicians and 13.3 percent for nurses) compared to no advice or usual care (4.8 percent for physicians and 11.3 percent for nurses). Study participants who receive tailored self-help materials are more likely to cease smoking at six months or more when compared to study participants who did not receive self-help materials (7.1 percent vs. 5.8 percent). The U.S. Prevention Services Task Force (USPSTF) has found evidence that smoking cessation decreases the risk for heart disease, lung disease, and stroke through a review of published literature. The USPSTF also highlights evidence that smoking and tobacco use cessation interventions (including counseling sessions and pharmacotherapy) are effective in increasing the proportion of patients who remain tobacco-free for at least 6 months to 1 year depending on length of intervention (Siu, 2015).

**Citations:**

Centers for Disease Control and Prevention. (2015). Current Cigarette Smoking Among Adults—United States, 2005–2014. Morbidity and Mortality Weekly Report;64(44):1233–40. Retrieved from <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6444a2.htm>

Siu, A. L. (2015). Behavioral and Pharmacotherapy Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Women: U.S. Preventive Services Task Force Recommendation Statement. Annals of Internal Medicine, 163(8), 622-635. Retrieved from: <http://annals.org/aim/article/2443060/behavioral-pharmacotherapy-interventions-tobacco-smoking-cessation-adults->

including-pregnant-women

U.S. Department of Health and Human Services (HHS). (2014). The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Retrieved from <https://www.surgeongeneral.gov/library/reports/50-years-of-progress/exec-summary.pdf>.

**S.4. Numerator Statement:** Advising Smokers and Tobacco Users to Quit:

Patients who indicated that they received advice to quit smoking or using tobacco from their doctor or health provider

Discussing Cessation Medications:

Patients who indicated that their doctor or health provider recommended or discussed smoking or tobacco cessation medications

Discussing Cessation Strategies:

Patients who indicated their doctor or health provider discussed or provided smoking or tobacco cessation methods and strategies other than medication

**S.6. Denominator Statement:** Patients 18 years and older who responded to the CAHPS survey and indicated that they were current smokers or tobacco users during the measurement year or in the last 6 months for Medicaid and Medicare.

**S.8. Denominator Exclusions:** None

**De.1. Measure Type:** Process

**S.17. Data Source:** Instrument-Based Data

**S.20. Level of Analysis:** Health Plan, Integrated Delivery System

**IF Endorsement Maintenance – Original Endorsement Date:** Aug 10, 2009 **Most Recent Endorsement Date:** Jun 28, 2017

**IF this measure is included in a composite, NQF Composite#/title:**

**IF this measure is paired/grouped, NQF#/title:**

**De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?** N/A

## 1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

### 1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[0027\\_MSC\\_Evidence\\_Form\\_2016-636179402077250670.docx](#)

#### 1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

Yes

### 1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

**1b.1. Briefly explain the rationale for this measure** (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

*If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.*

Tobacco smoking is the leading cause of preventable disease and death in the United States, resulting in approximately 480,000 premature deaths and more than \$300 billion in direct health care expenditures and productivity losses each year (HHS, 2014). Premature deaths due to smoking, including deaths from lung cancer, pulmonary diseases, coronary heart disease, pregnancy

concerns, and residential fires, numbered over 20 million between 1965 and 2014 (HHS, 2014). Although the consumption of cigarettes continues to decline (with a decrease from 20.9 percent in 2005 to 16.8 percent in 2014 (Centers for Disease Control and Prevention, 2015)), the use of electronic cigarettes, or e-cigarettes, has more than doubled between 2011 and 2012, especially among adolescents (HHS, 2014).

The strongest evidence on increasing smoking cessation comes from studies involving physician or nurse's advice, tailored self-help materials, or telephone counseling (Siu, 2015). For example, interventions that involve physician or nurse advice are associated with smoking abstinence at six months or more after the intervention (8.0 percent for physicians and 13.3 percent for nurses) compared to no advice or usual care (4.8 percent for physicians and 11.3 percent for nurses). Study participants who receive tailored self-help materials are more likely to cease smoking at six months or more when compared to study participants who did not receive self-help materials (7.1 percent vs. 5.8 percent). The U.S. Prevention Services Task Force (USPSTF) has found evidence that smoking cessation decreases the risk for heart disease, lung disease, and stroke through a review of published literature. The USPSTF also highlights evidence that smoking and tobacco use cessation interventions (including counseling sessions and pharmacotherapy) are effective in increasing the proportion of patients who remain tobacco-free for at least 6 months to 1 year depending on length of intervention (Siu, 2015).

#### Citations:

Centers for Disease Control and Prevention. (2015). Current Cigarette Smoking Among Adults—United States, 2005–2014. Morbidity and Mortality Weekly Report;64(44):1233–40. Retrieved from <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6444a2.htm>

Siu, A. L. (2015). Behavioral and Pharmacotherapy Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Women: U.S. Preventive Services Task Force Recommendation Statement. *Annals of Internal Medicine*, 163(8), 622–635. Retrieved from: <http://annals.org/aim/article/2443060/behavioral-pharmacotherapy-interventions-tobacco-smoking-cessation-adults-including-pregnant-women>

U.S. Department of Health and Human Services (HHS). (2014). The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Retrieved from <https://www.surgeongeneral.gov/library/reports/50-years-of-progress/exec-summary.pdf>.

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.**

The following data are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. Performance data is summarized at the health plan level and summarized by mean, standard deviation, minimum health plan performance, maximum health plan performance and performance at the 10th, 25th, 50th, 75th and 90th percentile. Data is stratified by year and product line (i.e. commercial, Medicaid, Medicare).

The following data demonstrate the variation in performance for all three rates across health plans. The difference in performance between plans in the 10th and 90th percentiles varies from 12 to 27 points across the three rates and product lines. This difference is greater for the Discussing Cessation Medications and Discussing Cessation Strategies rates; in 2016, for the Medicaid product line, the difference was 21 and 18 percentage points, respectively; for the commercial product line, the difference was 20 and 24 percentage points, respectively. In 2016, for the Advising Smokers to Quit rate, the difference was 15 percentage points for the Medicare product line, 17 percentage points for the commercial product line, and 14 percentage points for the Medicaid product line. These gaps in performance underscore the ongoing opportunity for improvement.

#### Advising Smokers to Quit

##### Medicare Rate

YEAR	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX	Interquartile Range
2014	84%	7%	61%	75%	81%	85%	89%	92%	100%	8%
2015	86%	6%	69%	78%	82%	86%	90%	93%	98%	8%
2016	86%	6%	69%	78%	82%	86%	90%	93%	98%	8%

#### Advising Smokers to Quit Rolling Average

##### Commercial Rate

YEAR	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX	Interquartile Range
2014	75%	8%	57%	66%	69%	74%	80%	85%	92%	11%
2015	75%	7%	60%	64%	70%	76%	79%	83%	92%	9%
2016	75%	7%	59%	66%	70%	75%	79%	83%	92%	9%

## Advising Smokers to Quit Rolling Average

## Medicaid Rate

## Commercial Rate

YEAR	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX	Interquartile Range
2014	76%	5%	54%	69%	74%	77%	79%	81%	87%	5%
2015	76%	6%	54%	68%	74%	77%	79%	82%	86%	5%
2016	76%	6%	60%	68%	73%	77%	79%	82%	91%	6%

## Discussing Cessation Medications

## Commercial Rate

YEAR	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX	Interquartile Range
2014	49%	9%	29%	37%	42%	49%	55%	61%	73%	13%
2015	49%	8%	32%	38%	43%	50%	53%	58%	71%	10%
2016	48%	8%	31%	41%	43%	48%	52%	61%	74%	9%

## Discussing Cessation Medications

## Medicaid Rate

YEAR	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX	Interquartile Range
2014	47%	8%	28%	38%	41%	46%	52%	57%	67%	11%
2015	47%	8%	19%	36%	42%	47%	52%	57%	65%	10%
2016	48%	8%	25%	37%	43%	48%	54%	58%	66%	11%

## Discussing Cessation Strategies

## Commercial Rate

YEAR	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX	Interquartile Range
2014	43%	10%	19%	30%	36%	42%	49%	57%	67%	13%
2015	44%	9%	26%	32%	38%	43%	50%	56%	65%	12%
2016	44%	9%	28%	34%	38%	42%	50%	58%	65%	12%

## Discussing Cessation Strategies

## Medicaid Rate

YEAR	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX	Interquartile Range
2014	42%	7%	26%	34%	38%	42%	45%	51%	59%	7%
2015	42%	7%	23%	34%	38%	43%	48%	51%	56%	10%
2016	43%	7%	27%	34%	39%	44%	48%	52%	61%	9%

In 2016, HEDIS measures covered 114.2 million commercial health plan beneficiaries, 47.0 million Medicaid beneficiaries, and 17.6 million Medicare beneficiaries. Below is a description of the denominator for this measure. It includes the number of health plans included in HEDIS data collection and the mean eligible population for the measure across health plans.

## Advising Smokers to Quit

## Medicare Rate

## YEAR | N Plans | Mean Denominator Size per plan

2014 | 316 | 57

2015 | 221 | 55

2016 | 238 | 55

## Advising Smokers to Quit Rolling Average

## Commercial Rate

## YEAR | N Plans | Mean Denominator Size per plan

2014 | 127 | 130  
2015 | 83 | 131  
2016 | 59 | 132

Advising Smokers to Quit Rolling Average

Medicaid Rate

YEAR | N Plans | Mean Denominator Size per plan

2014 | 137 | 275  
2015 | 139 | 274  
2016 | 159 | 257

Discussing Cessation Medications

Commercial Rate

YEAR | N Plans | Mean Denominator Size per plan

2014 | 126 | 130  
2015 | 83 | 130  
2016 | 58 | 132

Discussing Cessation Medications

Medicaid Rate

YEAR | N Plans | Mean Denominator Size per plan

2014 | 137 | 273  
2015 | 138 | 274  
2016 | 159 | 256

Discussing Cessation Strategies

Commercial Rate

YEAR | N Plans | Mean Denominator Size per plan

2014 | 123 | 130  
2015 | 82 | 130  
2016 | 58 | 131

Discussing Cessation Strategies

Medicaid Rate

YEAR | N Plans | Mean Denominator Size per plan

2014 | 137 | 273  
2015 | 139 | 272  
2016 | 159 | 256

**1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.**

N/A

**1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (*This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.**

NCQA does not currently report performance data stratified by race or ethnicity. While not specified in the measure, results from CAHPS surveys can be stratified by the health plan for demographic variables, such as race/ethnicity collected from the survey.

**1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if**

**performance data provided in 1b.4**

Although HEDIS measures are not stratified by race and ethnicity, researchers have explored disparities in the provision of smoking and tobacco cessation strategies and medications. Significant disparities in tobacco use are still present among certain racial/ethnic populations, and among groups defined by educational level, geographic region, sexual minorities (including the gay, lesbian, bisexual, and transgender community, and individuals with same-sex relationships or attraction), and severe mental illness (HHS, 2014). Men are more likely to be current smokers than women; 18.8 percent of men reported being current smokers in 2014 and 14.8 percent of women. Among racial and ethnic groups, the smoking prevalence is highest among American Indian/Alaska Natives (29.2 percent) and multiracial adults (27.9 percent), and lowest among Asians (9.5 percent). In regards to education, among adults aged ≥25 years, the prevalence was highest among persons with a General Education Development (GED) certificate (43.0 percent) and lowest among those with a graduate degree (5.4 percent). The occurrence of tobacco use is higher among lesbian, gay, or bisexual adults (23.9 percent) than among straight adults (16.6 percent). By region, Individuals living in the Midwest have the highest prevalence of tobacco use (20.7 percent) compared to those living in the West (13.1 percent). Individuals who do not report a disability or limitation have a lower prevalence of tobacco use (16.1 percent) compared to those who do report having a disability or limitation (23.9 percent) (Centers for Disease Control and Prevention, 2015).

Research studies are limited in information regarding smoking cessation and sexual minorities, severe mental illness, and geographic region. Lower socioeconomic individuals are more likely to discontinue pharmacotherapy interventions and have barriers to completing behavioral methods due to lack of knowledge, cost, and low self-efficacy (Hiscock et al., 2012). Adults >25 in age are more likely to use pharmacological treatments to aid in smoking cessation than their younger counterparts who are more likely to use support from friends or family (Curry et al., 2007). Women are more likely than men to have poorer smoking cessation outcomes due to multiple facts; perceived weight gain during cessation, lower self-efficacy, and anticipated negative tobacco use withdrawal symptoms (McKee et al., 2005).

**Citations:**

Centers for Disease Control and Prevention. (2015). Current Cigarette Smoking Among Adults—United States, 2005–2014. Morbidity and Mortality Weekly Report;64(44):1233–40. Retrieved from <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6444a2.htm>

Curry, S. J., Sporer, A. K., Pugach, O., Campbell, R. T., & Emery, S. (2007). Use of Tobacco Cessation Treatments Among Young Adult Smokers: 2005 National Health Interview Survey. American journal of public health, 97(8), 1464-1469.

Hiscock, R., Bauld, L., Amos, A., Fidler, J. A., & Munafò, M. (2012). Socioeconomic Status and Smoking: A Review. Annals of the New York Academy of Sciences, 1248(1), 107-123.

McKee, S. A., O'Malley, S. S., Salovey, P., Krishnan-Sarin, S., & Mazure, C. M. (2005). Perceived Risks and Benefits of Smoking Cessation: Gender-Specific Predictors of Motivation and Treatment Outcome. Addictive behaviors, 30(3), 423-435.

U.S. Department of Health and Human Services (HHS). (2014). The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Retrieved from <https://www.surgeongeneral.gov/library/reports/50-years-of-progress/exec-summary.pdf>.

## 2. Reliability and 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. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

**2a.1. Specifications** The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

**De.5. Subject/Topic Area** (check all the areas that apply):

**De.6. Non-Condition Specific**(check all the areas that apply):

Primary Prevention

**De.7. Target Population Category** (Check all the populations for which the measure is specified and tested if any):

Elderly, Populations at Risk, Populations at Risk : Dual eligible beneficiaries

**S.1. Measure-specific Web Page** (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

N/A

**S.2a. If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

**S.2b. Data Dictionary, Code Table, or Value Sets** (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

No data dictionary Attachment:

**S.2c.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Attachment Attachment: MSC\_Specification\_HEDIS\_2020\_-1-.docx

**S.2d.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Patient

**S.3.1. For maintenance of endorsement:** Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

No

**S.3.2. For maintenance of endorsement**, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

N/A

**S.4. Numerator Statement** (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Advising Smokers and Tobacco Users to Quit:

Patients who indicated that they received advice to quit smoking or using tobacco from their doctor or health provider

Discussing Cessation Medications:

Patients who indicated that their doctor or health provider recommended or discussed smoking or tobacco cessation medications

Discussing Cessation Strategies:

Patients who indicated their doctor or health provider discussed or provided smoking or tobacco cessation methods and strategies other than medication

**S.5. 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, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).



For the commercial product line:

- Advising Smokers and Tobacco Users to Quit:

The number of patients in the denominator who indicated that they received advice to quit smoking or tobacco use from a doctor or other health provider by answering "Sometimes" or "Usually" or "Always" to CAHPS question Q36: "In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?"

- Discussing Smoking Cessation Medications:

The number of patients in the denominator who indicated that their doctor or health provider recommended or discussed cessation medications to assist with quitting smoking or using tobacco by answering "Sometimes" or "Usually" or "Always" to CAHPS question Q37: "In the last 12 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication."

- Discussing Cessation Strategies:

The number of patients in the denominator who indicated that their doctor or health provider discussed or provided cessation methods and strategies other than medication to assist with quitting smoking or using tobacco by answering "Sometimes" or "Usually" or "Always" to CAHPS question Q38: "In the last 12 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program."

Response options for all questions:

Never, Sometimes, Usually, Always

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For the Medicaid product line:

- Advising Smokers and Tobacco Users to Quit:

The number of patients in the denominator who indicated that they received advice to quit smoking or tobacco use from a doctor or other health provider by answering "Sometimes" or "Usually" or "Always" to CAHPS question Q33: "In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?"

- Discussing Smoking Cessation Medications:

The number of patients in the denominator who indicated that their doctor or health provider recommended or discussed medication to assist with quitting smoking or using tobacco by answering "Sometimes" or "Usually" or "Always" to CAHPS question Q34: "In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication."

- Discussing Cessation Strategies:

The number of patients in the denominator who indicated that their doctor or health provider discussed or provided methods and strategies other than medication to assist with quitting smoking or using tobacco by answering "Sometimes" or "Usually" or "Always" to CAHPS question Q35: "In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program."

Response options for all questions:

Never, Sometimes, Usually, Always

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For the Medicare product line:

- Advising Smokers or Tobacco Users to Quit

The number of patients in the denominator who indicated that they received advice to quit smoking or using tobacco from a doctor or other health provider by answering "Sometimes" or "Usually" or "Always" to CAHPS question Q55 : "In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?"

Response options for all questions:



Never, Sometimes, Usually, Always, I had no visits in the last 6 months

**S.6. Denominator Statement** (Brief, narrative description of the target population being measured)

Patients 18 years and older who responded to the CAHPS survey and indicated that they were current smokers or tobacco users during the measurement year or in the last 6 months for Medicaid and Medicare.

**S.7. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

In order to be included in the denominator for each rate, patients must answer both the question about current cigarette/tobacco use and the relevant numerator question (eg, for the Advising Smokers and Tobacco Users to Quit rate, patients must answer the question about current cigarette/tobacco use and the question about how often they were advised to quit by a doctor or other health provider).

For the commercial product line:

- Advising Smokers and Tobacco Users to Quit

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q35 and by answering Q36 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q35: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q35: “Every day”, “Some days”, “Not at all”, “Don’t know”

Q36: “In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?”

Response options for Q36: “Never”, “Sometimes”, “Usually”, “Always”

- Discussing Cessation Medications

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q35 and by answering Q37 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q35: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q35: “Every day”, “Some days”, “Not at all”, “Don’t know”

Q37: “In the last 12 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.”

Response options for Q37: “Never” OR “Sometimes” OR “Usually” OR “Always”

- Discussing Cessation Strategies

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q35 and by answering Q38 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q35: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q35: “Every day”, “Some days”, “Not at all”, “Don’t know”

Q38: “In the last 12 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.”

Response options for Q38: “Never”, “Sometimes”, “Usually”, “Always”

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For the Medicaid product line:

- Advising Smokers and Tobacco Users to Quit

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering "Every day" or "Some days" to CAHPS question Q32 and by answering Q33 with any response ("Never" or "Sometimes" or "Usually" or "Always").

Q32: "Do you now smoke cigarettes or use tobacco every day, some days, or not at all?"

Response options for Q32: "Every day", "Some days", "Not at all", "Don't know"

Q33: "In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?"

Response options for Q33: "Never", "Sometimes", "Usually", "Always"

- Discussing Cessation Medications

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering "Every day" or "Some days" to CAHPS question Q32 and by answering Q34 with any response ("Never" or "Sometimes" or "Usually" or "Always").

Q32: "Do you now smoke cigarettes or use tobacco every day, some days, or not at all?"

Response options for Q32: "Every day", "Some days", "Not at all", "Don't know"

Q34: "In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication."

Response options for Q34: "Never", "Sometimes", "Usually", "Always"

- Discussing Cessation Strategies

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering "Every day" or "Some days" to CAHPS question Q32 and by answering Q35 with any response ("Never" or "Sometimes" or "Usually" or "Always").

Q32: "Do you now smoke cigarettes or use tobacco every day, some days, or not at all?"

Response options for Q32: "Every day", "Some days", "Not at all", "Don't know"

Q35: "In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program."

Response options for Q35: "Never", "Sometimes", "Usually", "Always"

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For the Medicare product line:

- Advising Smokers or Tobacco Users to Quit

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering "Every day" or "Some days" to CAHPS question Q54, had one or more visits during the last 6 months, and by answering Q55 with any response ("Never" or "Sometimes" or "Usually" or "Always").

Q54: "Do you now smoke cigarettes or use tobacco every day, some days, or not at all?"

Response options for Q54: "Not at all", "Some days", "Every day", "Don't know"

Q55: "In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?"

Response options for Q55: "Never", "Sometimes", "Usually", "Always", "I had no visits in the last 6 months"

The Medicare results for the Advising Smokers and Tobacco Users to Quit Rate requires a minimum denominator of at least 30 responses.

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

None

**S.9. Denominator Exclusion Details** (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

N/A

**S.10. Stratification Information** (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

None

**S.11. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

**S.12. Type of score:**

Rate/proportion

If other:

**S.13. 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

**S.14. Calculation Algorithm/Measure Logic** (Diagram or 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; time period for data, aggregating data; risk adjustment; etc.)

Step 1: Identify the eligible population of commercial, Medicaid and Medicare CAHPS respondents

Step 2: Identify the denominator for each component.

Step 3: Identify the numerator for each component.

Step 4: Calculate the rate as numerator/denominator.

For the commercial and Medicaid product lines, rolling averages are calculated using the formula below.

Rate = (Year 1 Numerator + Year 2 Numerator)/(Year 1 Denominator + Year 2 Denominator)

NCQA calculates a result when the denominator is 100 individuals or more.

If the health plan did not report results in the prior year (Year 1), but reports results for the current year and achieves a denominator of 100 or more, NCQA calculates a rate.

For the Medicare product line, this is collected by the Centers for Medicare & Medicaid Services through the Medicare CAHPS Survey. This is collected on an annual basis.

**S.15. Sampling** (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

If an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

A systematic sampling method is used for the CAHPS survey. Required sample sizes are based on the goal of achieving 411 complete and valid surveys. To establish required sample sizes, NCQA evaluates a health plan's prior year's survey results and analyzes the

following.

- Survey response rates (mean, median and distribution of response rates)
- The average number of complete and valid surveys achieved
- The percentage of members in the sample who were ineligible
- The percentage of members in the sample who, because of a bad address or telephone number, were unable to be contacted by the survey vendor
- The percentage of members who refused to participate in the survey

For each HEDIS/CAHPS survey administered, the survey vendor draws a random sample of members, employing the required sample size as indicated in Table S-3. In a health plan with fewer eligible members than the required sample size, the sample includes the health plan's entire eligible population. To reduce respondent burden, the survey vendor deduplicates samples so that only one adult member per household is included in the adult sample and only one child member per household is included in the child sample.

**Table S-3: Survey Sample Sizes**

**Survey Type Required Sample Size**

Adult commercial 1,100

Adult Medicaid 1,350

Child commercial 900

Child Medicaid 1,650

**Proxy Responses:** Proxy responses are not permitted for the adult CAHPS survey; the sampled member must complete his or her own survey.

**Medicare CAHPS:** CMS provide the sample for the Medicare CAHPS survey.

**S.16. Survey/Patient-reported data** *(If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)*

Specify calculation of response rates to be reported with performance measure results.

Health plans select one of two standard options for administering the CAHPS surveys:

1. The mail-only methodology, a five-wave mail protocol with three questionnaire mailings and two reminder postcards.
2. The mixed methodology, a four-wave mail protocol (two questionnaires and two reminder postcards) with telephone follow-up of a minimum of three and a maximum of six telephone attempts.

Confidentiality of sampled members must be maintained. Neither NCQA nor the health plan has access to the names of individuals selected for the survey.

**S.17. Data Source** *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*

*If other, please describe in S.18.*

Instrument-Based Data

**S.18. Data Source or Collection Instrument** *(Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)*

If instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

CAHPS Health Plan Survey 5.0H, Adult Version; Medicare CAHPS

<http://www.ahrq.gov/cahps/index.html>

**S.19. Data Source or Collection Instrument** *(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)*

Available at measure-specific web page URL identified in S.1

**S.20. Level of Analysis** *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)*

Health Plan, Integrated Delivery System

**S.21. Care Setting** (Check *ONLY* the settings for which the measure is SPECIFIED AND TESTED)

Other: In addition to clinician visits, some respondents may recall contacts with an “other health provider” (the wording used in the survey question), which may include contacts with nurses or health plan staff., Outpatient Services

If other:

**S.22. COMPOSITE Performance Measure** - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

**2. Validity – See attached Measure Testing Submission Form**

[0027\\_MSC\\_Testing\\_Form\\_2016\\_Updated.docx](#)

**2.1 For maintenance of endorsement**

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

**2.2 For maintenance of endorsement**

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

**2.3 For maintenance of endorsement**

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1, 2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

**3. Feasibility**

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

**3a. Byproduct of Care Processes**

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

**3a.1. Data Elements Generated as Byproduct of Care Processes.**

Other

If other: [Patient Survey](#)

**3b. Electronic Sources**

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

**3b.1. To what extent are the specified data elements available electronically in defined fields** (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for **maintenance of endorsement**.

[Patient/family reported information \(may be electronic or paper\)](#)

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a**

**credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.** For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

The data for this measure comes from a patient-reported survey.

**3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.**

**Attachment:**

### **3c. Data Collection Strategy**

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

**3c.1. Required for maintenance of endorsement.** Describe difficulties (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.

**IF instrument-based,** consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

NCQA uses several mechanisms to solicit feedback from plans that participate in HEDIS reporting, including a Policy Clarification Support System and a HEDIS Users' Group. The Policy Clarification Support System allows NCQA to collect "real-time" feedback from measure users; through this system, NCQA receives thousands of inquiries each year on over 100 measures. The HEDIS Users' Group has 195 members for 2017; participation includes four conferences presented by NCQA to address key HEDIS implementation issues. NCQA has not heard about difficulties implementing this measure.

**3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).**

Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

## **4. Usability and Use**

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

### **4a. Accountability and Transparency**

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

#### **4.1. Current and Planned Use**

*NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.*

Specific Plan for Use	Current Use (for current use provide URL)

**4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:**

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

- Level of measurement and setting

**ANNUAL STATE OF HEALTH CARE QUALITY REPORT:** This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2015 the report included data from 814 HMOs and 353 PPOs, representing more than 171 million patients.

**CMS HEALTH INSURANCE MARKET QUALITY RATING SYSTEM:** This measure is used in the CMS developed, Quality Reporting Rating System (QRS) set of measures. The QRS measure set consists of measures that address areas of clinical quality management; enrollee experience; and plan efficiency, affordability and management. The measure set includes a subset of NCQA's HEDIS measures and one PQA measure.

**HEALTH PLAN RATINGS/REPORT CARDS:** This measure is used to calculate health plan ratings for Medicaid and Medicare health plan, which are reported in Consumer Reports and on the NCQA website. These rankings are based on performance on HEDIS measures among other factors. In 2012, a total of 455 Medicare Advantage health plans and 136 Medicaid health plans across 50 states were included in the rankings.

**HEALTH PLAN ACCREDITATION:** This measure is used in scoring for accreditation of commercial, Medicare Advantage and Medicaid health plans. In 2012, a total of 336 commercial health plans covering 87 million lives, 170 Medicare Advantage health plans covering 7.1 million Medicare beneficiaries, and 77 Medicaid health plans covering 9.1 million lives were accredited using this measure among others. Health plans are scored based on performance compared to benchmarks.

**MEDICAID ADULT CORE SET:** These are a core set of health quality measures for Medicaid-enrolled adults. The Medicaid Adult Core Set was identified by the Centers for Medicare & Medicaid (CMS) in partnership with the Agency for HealthCare Research and Quality (AHRQ). The data collected from these measures will help CMS to better understand the quality of health care that adults enrolled in Medicaid receive nationally. Beginning in January 2014 and every three years thereafter, the Secretary is required to report to Congress on the quality of care received by adults enrolled in Medicaid. Additionally, beginning in September 2014, state data on the adult quality measures will become part of the Secretary's annual report on the quality of care for adults enrolled in Medicaid.

**QUALITY COMPASS:** This measure is used in Quality Compass which is an indispensable tool used for selecting a health plan, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

**4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons?** (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

N/A

**4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement.** (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

N/A

**4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.**

**How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.**

Health plans that report HEDIS calculate their rates and know their performance when submitting to NCQA. NCQA publicly reports rates across all plans and also creates benchmarks in order to help plans understand how they perform relative to other plans. Public reporting and benchmarking are effective quality improvement methods.

**4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.**



NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual HEDIS Update and Best Practices Conference, NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly. NCQA also regularly provides technical assistance on measures through its Policy Clarification Support System, as described in Section 3c1.

**4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.**

**Describe how feedback was obtained.**

NCQA measures are evaluated regularly. During this "reevaluation" process, we seek broad input on the measure, including input on performance and implementation experience. We use several methods to obtain input, including vetting of the measure with several multi-stakeholder advisory panels, public comment posting, and review of questions submitted to the Policy Clarification Support System. This information enables NCQA to comprehensively assess a measure's adherence to the HEDIS Desirable Attributes of Relevance, Scientific Soundness and Feasibility.

**4a2.2.2. Summarize the feedback obtained from those being measured.**

In general, health plans have not reported significant barriers to implementing this measure.

**4a2.2.3. Summarize the feedback obtained from other users**

This measure has been deemed a priority measure by NCQA and other entities, as illustrated by its use in programs such as the Medicaid Adult Core Set and the CMS Health Insurance Market Quality Rating System

**4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.**

Feedback has not required modification to this measure.

**Improvement**

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

**4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)**

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

Between 2014 to 2016, the trend across all three rates and product lines has been stable or improved performance. For the Medicare product line, the average performance has improved two percentage points for the Advising Smokers to Quit rate. Average performance has remained stable on this rate for the commercial and Medicaid product lines. For the Discussing Cessation Medications rate, the average performance for the commercial product line has dropped one percentage point, and for the Medicaid product line it has improved one percentage point. For the Discussing Cessation Strategies rate, the average performance for both the commercial and Medicaid product lines has improved one performance point.

**4b2. Unintended Consequences**

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

**4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.**

There were no identified unintended consequences for this measure during testing or since implementation.

**4b2.2. Please explain any unexpected benefits from implementation of this measure.**

There were no identified unexpected benefits for this measure during testing or since implementation.

## 5. Comparison to Related or 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.

### 5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

#### 5.1a. List of related or competing measures (selected from NQF-endorsed measures)

0028 : Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

2600 : Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

2803 : Tobacco Use and Help with Quitting Among Adolescents

#### 5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

### 5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

#### 5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

No

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

Refer to 5b.1

### 5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

#### 5b.1. If this measure conceptually addresses 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.)

Answer for 5a.2: Identify differences, rationale, and impact on interpretability and data collection burden:

Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (NQF #0028, stewarded by the AMA-convened Physician Consortium for Performance Improvement [AMA-PCPI]) evaluates the “percentage of patients 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as tobacco user”; “cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy.” The denominator includes “patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period”; patients are excluded from the measure if there is “documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy).” It differs from NCQA’s measure under review because it: 1) requires screening and intervention once every two years (rather than once every two); 2) includes only those patients who have had at least two visits or at least one preventive visit during the measurement period; and 3) excludes patients with a medical reason for not screening for tobacco use. Regarding the timing of screening and interventions, the USPSTF recommendation does not provide guidance about the frequency of screening or providing tobacco cessation interventions. Because of the harm caused by tobacco use and the positive outcomes associated with tobacco use cessation, NCQA has decided to assess smoking and tobacco use cessation on an annual basis, rather than biannual basis. Regarding the visit requirement in the encounter, the AMA-PCPI measure

is specified for individual clinicians and groups/practices, whereas the NCQA measure is specified for health plans. Because health plans may engage individuals in tobacco cessation outside of clinical visits, we chose not to require visits in the denominator. Lastly, regarding the medical reason exclusion, NCQA does not expect this type of exclusion to have a significant impact at the health plan level; therefore, we do not include this type of exclusion in the NCQA measure.

Tobacco Use and Help with Quitting Among Adolescents (NQF #2803, stewarded by the National Committee for Quality Assurance) evaluates the “percentage of adolescents 12 to 20 years of age during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.” There are no exclusions for the measure. It differs from NCQA’s measure under review because it: 1) includes an evaluation of whether or not adolescents received tobacco screening; and 2) it focuses on adolescents rather than adults. It is specified for the clinician: group/practice level and EHR only. NCQA’s measure under review focuses on evaluating whether patients who are current smokers or tobacco users receive information from their doctor or health provider about recommended cessation interventions. It also reports separate rates for the different recommended cessation interventions (advice, cessation medications, and cessation strategies), whereas the Tobacco Use and Help with Quitting Among Adolescents measure evaluates whether adolescents received any of the following: advice to quit, counseling on the benefits of quitting, assistance with or referral to a cessation support program, or current enrollment in a cessation program.

Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence (NQF #2600, stewarded by the National Committee on Quality Assurance) evaluates the “percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user.” There are two rates; rate 1 focuses on patients with a diagnosis of serious mental illness; rate 2 focuses on patients with a diagnosis of alcohol or other drug dependence. This measure is adapted from Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (NQF #0028). There are no exclusions. It is specified at the health-plan level. The differences between NCQA’s measure under review and this measure are similar as the differences between NCQA’s measure under review and the AMA-PCPI measure, although this measure does not have exclusions. This measure is specified at the health plan measure, as is NCQA’s measure under review; however, it focuses on a specific, at-risk population (patients with a serious mental illness or alcohol or other drug dependence).

## Appendix

**A.1 Supplemental materials may be provided in an appendix.** All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

**No appendix Attachment:**

## Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** National Committee for Quality Assurance

**Co.2 Point of Contact:** Bob, Rehm, [nqf@ncqa.org](mailto:nqf@ncqa.org), 202-955-1728-

**Co.3 Measure Developer if different from Measure Steward:** National Committee for Quality Assurance

**Co.4 Point of Contact:** Kristen, Swift, [swift@ncqa.org](mailto:swift@ncqa.org), 202-955-5174-

## Additional Information

**Ad.1 Workgroup/Expert Panel involved in measure development**

**Provide a list of sponsoring organizations and workgroup/panel members’ names and organizations. Describe the members’ role in measure development.**

Committee on Performance Measurement (CPM)

Bruce Bagley, MD, American Medical Association & American Association for Physician Leadership

Andrew Baskin, MD, Aetna

Patrick Conway, MD, MSC, Center for Medicare & Medicaid Services

Jonathan D. Darer, MD, MPH, Medicalis

Helen Darling, Interim – National Quality Forum

Rebekah Gee, MD, MPH, FACOG, LSU School of Medicine and Public Health

Foster Gesten, MD, NY State Department of Health

David Grossman, MD, MPH, Group Health Physician  
Christine S. Hunter, MD (Co-Chair), US Office of Personnel Management  
Jeffrey Kelman, MMSc, MD, Centers for Medicare & Medicaid Services  
Nancy Lane, PhD, Vanderbilt University Medical Center  
Bernadette Loftus, MD, The Permanente Medical Group  
Amanda Parsons, MD, Montefiore Health System  
J. Brent Pawlecki, MD, MMM, The Goodyear Tire & Rubber Company  
Susan Reinhard, PhD, RN, AARP Public Policy Institute  
Eric C Schneider, MD, MSc, FACP (Co-Chair), The Commonwealth Fund  
Marcus Thygeson, MD, MPH, Blue Shield of California  
JoAnn Volk, MA, Georgetown University Center on Health Insurance Reforms

Smoking Cessation measure Workgroup: Steven Bernstein, Jonathan Foulds, Eric Heiligenstein, Corinne Husten, Carlos Jaen, Nancy Rigotti, Lowell Dale, Steve Schroeder, and David Warner

Cardiovascular MAP  
Stephen D. Persell MD, MPH (Chair)  
Kathy Berra, MSN, ANP, FAAN  
David C. Goff, Jr., MD, PhD  
Clarion Johnson, MD  
Tom Kottke, MD  
Eduardo Ortiz MD, MPH  
Michael Pignone, MD, MPH  
Randall S. Stafford, MD, PhD  
Tracy Wolff, MD  
Corinne Husten, MD, MPH  
Samantha Tierney, MPH (Liaison)  
Jason M. Spangler, MD, MPH, FACPM (Liaison)

The NCQA Smoking Cessation Measure Workgroup advised NCQA during measure development. They evaluated the way staff specified measures, assessed the content validity of measures, and reviewed field test results. As you can see from the list, the MAP consisted of a balanced group of experts, including representatives from primary care. Note that, in addition to the MAP, we also vetted these measures with a host of other stakeholders, as is our process. Thus, our measures are the result of consensus from a broad and diverse group of stakeholders, in addition to the MAP. The CVMAP advised on the first year analysis results.

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

**Ad.2 Year the measure was first released:** 1997

**Ad.3 Month and Year of most recent revision:** 2009

**Ad.4 What is your frequency for review/update of this measure?** Approximately every 3-5 years or dependent on new guidelines or evidence.

**Ad.5 When is the next scheduled review/update for this measure?** 12, 2017

**Ad.6 Copyright statement:** © 2012 by the National Committee for Quality Assurance

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**Ad.7 Disclaimers:**

**Ad.8 Additional Information/Comments:** For the survey instrument:

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