



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 #: 0379

Corresponding Measures:

De.2. Measure Title: Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry

Co.1.1. Measure Steward: American Society of Hematology

De.3. Brief Description of Measure: Percentage of patients aged 18 years and older, seen within a 12 month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period who had baseline flow cytometry studies performed and documented in the chart

1b.1. Developer Rationale: Due to the distinct pattern of protein antigens expressed in CLL, flow cytometry should be performed in order to confirm the diagnosis, correctly characterize the pathological cells, and determine prognosis. In some instances, flow cytometry may also offer additional therapeutically relevant information. By encouraging the performance of flow cytometry testing for all CLL patients, this measure may thus have diagnostic, prognostic and therapeutic benefits for these patients.

S.4. Numerator Statement: Patients who had baseline flow cytometry studies performed and documented in the chart

S.6. Denominator Statement: All patients aged 18 years and older, seen within a 12 month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period

S.8. Denominator Exclusions: For Claims/Registry:

Documentation of medical reason(s) for not performing baseline flow cytometry studies

Documentation of patient reason(s) for not performing baseline flow cytometry studies (eg, receiving palliative care or not receiving treatment as defined above)

Documentation of system reason(s) for not performing baseline flow cytometry studies (eg, patient previously treated by another physician at the time baseline flow cytometry studies were performed)

De.1. Measure Type: Process

S.17. Data Source: Claims (Only), Registry

S.20. Level of Analysis: Clinician : Group/Practice, Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: Jul 31, 2008 **Most Recent Endorsement Date:** Aug 09, 2012

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?

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

[0379_Evidence_MSF5.0_Data.doc](#)

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

Please update any changes in the evidence attachment in red. Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. If there is no new evidence, no updating of the evidence information is needed.

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 PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

IF a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and provide rationale for composite in question 1c.3 on the composite tab.

Due to the distinct pattern of protein antigens expressed in CLL, flow cytometry should be performed in order to confirm the diagnosis, correctly characterize the pathological cells, and determine prognosis. In some instances, flow cytometry may also offer additional therapeutically relevant information. By encouraging the performance of flow cytometry testing for all CLL patients, this measure may thus have diagnostic, prognostic and therapeutic benefits for these patients.

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 (4b) under Usability and Use.

Using the SEER Medicare database, a study analyzing 5086 patients by Friese et al, found that approximately half of patients (2282) had claim for flow cytometry at any time during the 10 year study period; 1965 (38.6%) patients had their initial flow cytometry performed within 30 days before or after the SEER diagnosis date.

CMS Physician Quality Reporting Initiative

This measure was used in the 2007-2010 CMS Physician Quality Reporting Initiative Claims and Registry options.

Amongst eligible professionals reporting on this measure in 2008, their performance rate varies as follows:

There is a gap in care as shown by this 2008 data; 38.32% of patients reported on did not meet the measure.

10th percentile: 18.18%
 25th percentile: 40.00%
 50th percentile: 66.67%
 75th percentile: 90.91%
 90th percentile: 100.00%

The mean performance rate for 2009 was reported as 92.59% with a total of 1,740 eligible professionals submitting. demonstrating an opportunity for improvement. Unfortunately, data regarding the variability in performance rates across reporting eligible professionals for PQRS 2009 is not available at this time.

PQRS is a voluntary reporting program and performance rates may not be representative of all physicians treating patients with MDS.

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.

Friese CR, Earle CC, Magazu LS. Timeliness and Quality of Diagnostic Care for Medicare Recipients with Chronic Lymphocytic Leukemia. Cancer 2011, American Cancer Society

Confidential CMS PQRI 2008 and 2009 Performance Information by Measure. Jan-Sept TAP file.

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 (4b) under Usability and Use.*

We are not aware of any publications/evidence outlining disparities specific to the use of flow cytometry however the following articles outline more general diagnostic treatment disparities related to CLL:

Between 1997 and 2007, in a study by Preen, et al looking at 30,622 cases of CLL/SLL the researchers concluded that males had higher rates, in comparison to females. Additionally, African American patients seemed to be diagnosed at a younger age compared to Caucasian patients. Lastly, though African American patients show symptoms at a younger age the survival rates were not as strong for African American patients with CLL.

Using the SEER Medicare database, a study analyzing 5086 patients by Friese et al, found that patients who are female and sicker tend to experience greater delays in diagnosis for CLL. Because it is more and more likely that primary care providers will be tasked with the initial diagnoses of CLL, it is important to recognize this gap in care for all providers. There is evidence of a gender gap, namely that men are diagnosed more quickly compared to women. Additionally, there was evidence to show that patient characteristics could influence whether or not patients received baseline flow cytometry. As baseline flow cytometry is associated with improved survival, it is a critical component of care. Results of the study show that for the 5086 patients analyzed, the median time between sign or symptom and CLL diagnosis was 63 days (interquartile range [IQR] = 0-251).

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

Racial Differences in the Presentation and Outcomes of Chronic Lymphocytic Leukemia and Variants in the United States. Shenoy PJ, Malik N, Sinha R, et al. Volume 11, Issue 6, December 2011, Clinical Lymphoma Myeloma and Leukemia, Pages 498-506.

Friese CR, Earle CC, Magazu LS. Timeliness and Quality of Diagnostic Care for Medicare Recipients with Chronic Lymphocytic Leukemia. Cancer 2011, American Cancer Society

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):
Cancer, Cancer : Hematologic

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

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

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.)

The measure specifications are included with this form. Additional measure details may be found at <http://www.hematology.org/Clinicians/Guidelines-Quality/PQRS/503.aspx>

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.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.

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.

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).

[Patients who had baseline flow cytometry studies performed and documented in the chart](#)

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).

Definition:

Baseline Flow Cytometry Studies – Refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. Treatment may include anti-neoplastic therapy.

For Claims/Registry:

Report the CPT Category II code: 3170F - Flow cytometry studies performed at time of diagnosis or prior to initiating treatment

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

All patients aged 18 years and older, seen within a 12 month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period

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).

For Claims/Registry:

Patients aged ≥ 18 years

AND

Diagnosis for CLL – not in remission (ICD-9-CM) [reportable through 9/30/2015]: 204.10, 204.12

Diagnosis for CLL – not in remission (ICD-10-CM) [reportable beginning 10/01/2015]: C91.10, C91.12

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

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

For Claims/Registry:

Documentation of medical reason(s) for not performing baseline flow cytometry studies

Documentation of patient reason(s) for not performing baseline flow cytometry studies (eg, receiving palliative care or not receiving treatment as defined above)

Documentation of system reason(s) for not performing baseline flow cytometry studies (eg, patient previously treated by another physician at the time baseline flow cytometry studies were performed)

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.)*

This measure was developed using the PCPI methodology, which exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry, exceptions may include medical reason(s), patient reason(s) (eg, receiving palliative care or not receiving treatment as defined above) or system reason(s) for the patient not performing baseline flow cytometry studies (eg, patient previously treated by another physician at the time baseline flow cytometry studies were performed). Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Additional details by data source are as follows:

For Claims/Registry:

Documentation of medical reason(s) for not performing baseline flow cytometry studies – Append modifier to CPT Category II code: 3170F-1P

Documentation of patient reason(s) for not performing baseline flow cytometry studies (eg, receiving palliative care or not receiving treatment as defined above) – Append modifier to CPT Category II code: 3710F-2P

Documentation of system reason(s) for not performing baseline flow cytometry studies (eg, patient previously treated by another physician at the time baseline flow cytometry studies were performed) – Append modifier to CPT Category II code: 3170-3P

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.)

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF, the American Society of Hematology and PCPI encourage collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

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.)

To calculate performance rates:

- 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).
- 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.
- 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator
- 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [For this measure: exceptions may include medical reason, e.g. for not performing baseline flow cytometry; patient reason, e.g. for not performing baseline flow cytometry (for example, receiving palliative care or not receiving treatment as defined above) or system reason, e.g. for not performing baseline flow cytometry (for example, patient previously treated by another physician at the time baseline flow cytometry studies were performed)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

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

If a PRO-PM, identify whether (and how) proxy responses are allowed.

Not applicable. The measure does not require sampling or a 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.)

If a PRO-PM, specify calculation of response rates to be reported with performance measure results.

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

If other, please describe in S.18.

Claims (Only), Registry

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 is collected.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

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)

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

Clinician : Group/Practice, Clinician : Individual

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

Clinician Office/Clinic

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

[0379_MeasureTesting_MS5.0_Data.doc](#)

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. (Do not remove prior testing information – include date of new information in red.)

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. (Do not remove prior testing information – include date of new information in red.)

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes SDS factors is no longer prohibited during the SDS Trial Period (2015-2016). Please update sections 1.8, 2a2, 2b2, 2b4, and 2b6 in the Testing attachment and S.14 and S.15 in the online submission form in accordance with the requirements for the SDS Trial Period. NOTE: These sections must be updated even if SDS factors are not included in the risk-adjustment strategy. If yes, and your testing attachment does not have the additional questions for the SDS Trial please add these questions to your testing attachment:

What were the patient-level sociodemographic (SDS) variables that were available and analyzed in the data or sample used? For example, patient-reported data (e.g., income, education, language), proxy variables when SDS data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate).

Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or sociodemographic factors) used in the statistical risk model or for stratification by risk (e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of $p < 0.10$; correlation of x or higher; patient factors should be present at the start of care)

What were the statistical results of the analyses used to select risk factors?

Describe the analyses and interpretation resulting in the decision to select SDS factors (e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects)

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.

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

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.

ALL data elements are in defined fields in electronic health records (EHRs)

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).

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 a PRO-PM, consider implications for both individuals providing PRO data (patients, service recipients, respondents) and those whose performance is being measured.

The collection, availability, timing and frequency of measure calculation 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 measures were specific to the population.

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*).

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)
Public Reporting	
Payment Program	
Professional Certification or Recognition Program	
Quality Improvement (Internal to the specific organization)	

4a.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

4a.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?)**4a.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.)****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.

4b. 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.

4c. 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).

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

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

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

4d1.1. 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.

4d1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

4d2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

4d2.2. Summarize the feedback obtained from those being measured.

4d2.3. Summarize the feedback obtained from other users

4d.3. Describe how the feedback described in 4d.2 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

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.

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

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?

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

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.)

[No related or competing measures](#)

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.

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [American Society of Hematology](#)

Co.2 Point of Contact: [Robert Plovnick, rplovnick@hematology.org, 202-629-5081-](#)

Co.3 Measure Developer if different from Measure Steward: [AMA-PCPI](#)

Co.4 Point of Contact: [Mark Antman, mark.antman@ama-assn.org, 312-464-5056-](#)

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.

[Steven L. Allen, MD \(Co-Chair\) \(hematology/oncology\)](#)

[William E. Golden, MD \(Co-Chair\) \(internal medicine \(IM\)\)](#)

[Kenneth Adler, MD \(hematology/IM\)](#)

[Daniel Halevy, MD \(nephrology\)](#)

[Stuart Henochowicz, MD, MBA \(IM\)](#)

[Timothy Miley, MD \(hematopathology\)](#)

[David Morris, MD \(radiation oncology\)](#)

[John M. Rainey, MD \(medical oncology\)](#)

[Samuel M. Silver, MD, PhD \(hematology/oncology\)](#)

[Lawrence Solberg, Jr., MD, PhD \(hematology/IM\)](#)

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.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2007

Ad.3 Month and Year of most recent revision: 09, 2010

Ad.4 What is your frequency for review/update of this measure? Coding/Specifications updates occur annually. See additional information below:

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

Ad.6 Copyright statement:

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: Coding/Specifications updates occur annually. The PCPI has a formal measurement review process that stipulates regular (usually on a three-year cycle, when feasible) review of the measures. The process can also be activated if there is a major change in scientific evidence, results from testing or other issues are noted that materially affect the integrity of the measure.