NATIONAL QUALITY FORUM

Measure Submission and Evaluation Worksheet 5.0

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

NQF #: 0625　　　**NQF Project:** Cancer Project
(for Endorsement Maintenance Review) **Original Endorsement Date:** Dec 04, 2009　**Most Recent Endorsement Date:** Dec 04, 2009 **Last Updated Date:** Jul 12, 2013

BRIEF MEASURE INFORMATION
De.1 Measure Title: History of Prostate Cancer - Cancer Surveillance
Co.1.1 Measure Steward: ActiveHealth Management
De.2 Brief Description of Measure: The percentage of men with definitively treated localized prostate cancer who had at least one PSA level in the past 12 months.
2a1.1 Numerator Statement: Men who had at least one PSA level in the past 12 months.
2a1.4 Denominator Statement: Men with localized prostate cancer who were treated with curative intent.
2a1.8 Denominator Exclusions: 1. Surgical treatment for prostate cancer in the past year 2. Drug treatment for prostate cancer in the past year 3. Radiation therapy for prostate cancer in the past year 4. Prostate MRI in past year 5. Prostate biopsy in the past year 6. Metastatic prostate cancer 7. Provider or patient feedback stating patient does not have a diagnosis of prostate cancer. 8. General exclusions 　a. Terminal Illness 　b. Active treatment of malignancy (chemotherapy or radiation therapy) in the past 6 months. 　c. Patients who were admitted to a skilled nursing facility in the past 3 months.
1.1 Measure Type: Process **2a1. 25-26 Data Source:** Administrative claims, Electronic Clinical Data, Healthcare Provider Survey, Patient Reported Data/Survey **2a1.33 Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Facility, Health Plan, Population : County or City, Population : National, Population : State **1.2-1.4 Is this measure paired with another measure?** No **De.3 If included in a composite, please identify the composite measure** (*title and NQF number if endorsed*)**:** Not applicable.

STAFF NOTES (*issues or questions regarding any criteria*)
Comments on Conditions for Consideration:
Is the measure untested?　Yes◉　No◉　If untested, explain how it meets criteria for consideration

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

for time-limited endorsement:
1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (*check De.5*): **5. Similar/related endorsed or submitted measures** (*check 5.1*): **Other Criteria:**
Staff Reviewer Name(s):

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

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

***Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.* (evaluation criteria)**

1a. High Impact: H⦿ M⦿ L⦿ I ⦿
(*The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.*)

De.4 Subject/Topic Areas (*Check all the areas that apply*):   GU/GYN
De.5 Cross Cutting Areas (*Check all the areas that apply*):   Population Health

1a.1 Demonstrated High Impact Aspect of Healthcare: A leading cause of morbidity/mortality

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

1a.3 Summary of Evidence of High Impact (*Provide epidemiologic or resource use data*)**:**
In terms of the 2011 incidence data from the American Cancer Society, prostate cancer is the common cancer in men in the United States. It is the second most common cause of cancer deaths in men, with as estimated 33,700 cases in 2011, accounting for 11% of all cancers. Although screening for prostate cancer and the decision of when and who to treat remains controversial, appropriate follow-up for those men who have already received definitive therapy [therapy with curative intent] is not.

Men who have relapsed after definitive therapy are clearly at risk for dying of prostate cancer. Early detection and appropriate therapy is key to curing those who still have a chance for salvage curative therapy, as well as determining choice of therapy for those who are not candidates for salvage cure.

1a.4 Citations for Evidence of High Impact cited in 1a.3: 1. American Cancer Society. Cancer Facts & Figures 2011. Atlanta: American Cancer Society; 2011.

2. Howlader N, Noone AM, Krapcho M, Neyman N, Aminou R, Waldron W, Altekruse SF, Kosary CL, Ruhl J, Tatalovich Z, Cho H, Mariotto A, Eisner MP, Lewis DR, Chen HS, Feuer EJ, Cronin KA, Edwards BK (eds). SEER Cancer Statistics Review, 1975-2008, National Cancer Institute. Bethesda, MD, http://seer.cancer.gov/csr/1975_2008/, based on November 2010 SEER data submission, posted to the SEER web site, 2011.

1b. Opportunity for Improvement: H⦿ M⦿ L⦿ I ⦿
(*There is a demonstrated performance gap - variability or overall less than optimal performance*)

1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:
The 2006 IOM report on Cancer Survivorship outlined many steps that should be implemented to improve on follow-up care after curative therapy for cancer. The most important recommendation stemming from the report is the adherence to recommended surveillance and side-effect monitoring.

Prostate cancer is the second leading cause of cancer deaths in men in the US. Whether initial definitive therapy is given up front or after a period of active surveillance, relapsed prostate cancer can still be cured by RT if detected early enough in men who have a local recurrence after initial surgical therapy. The opposite scenario is also possible, though much more difficult to achieve. In addition, now there are therapies that have been shown to prolong survival in metastatic prostate cancer. These therapies are determined by response to hormone therapy, the PSA doubling time [which can only be determined by serial PSA testing], and extent of disease.

We envision this measure will lead to a decrease in mortality from relapsed prostate cancer, and in addition, increase enrollment into clinical trials designed to look at therapy for those who have relapsed and are not candidates for curative salvage therapy.

1b.2 **Summary of Data Demonstrating Performance Gap** *(Variation or overall less than optimal performance across providers)*: [*For Maintenance – Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.*]
There is very limited published data regarding how many men do not receive appropriate follow-up after definitive treatment of prostate cancer. ActiveHealth benchmark data has demonstrated that gaps can be detected. Our 2011 data show 20% men identified by this measure indeed did not have the recommended follow-up PSA and the treating physician planned to follow our recommendations.

1b.3 **Citations for Data on Performance Gap:** [*For Maintenance – Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]
None.

1b.4 **Summary of Data on Disparities by Population Group:** [*For Maintenance –Descriptive statistics for performance results for this measure by population group*]
Several studies have addressed the issue of disparities by population group as they relate to therapeutic modality and survival. In one of the largest studies, the CDC-NPCR Patterns of Care Study [PoC1], published in 2010, survival of patients was related to age, marital status, Gleason score, co-morbid illnesses, type of treatment, and state of residence. In this study, survival did not differ by race once all of the confounding variables were accounted for.

In this study, the risk of death from any cause increased substantially with age. Hispanic men had a significantly lower risk of death than non-Hispanic white men; this difference remained borderline significant after adjusting for other factors (p = 0.0511). Married men had a lower risk of death than unmarried men; this difference also remained borderline significant after adjustment (p = 0.0551). Five-year survival rates varied by state of residence, from 78.8% for Louisiana to 90.0% for Colorado. After adjusting for other factors, the hazard ratio remained significantly higher (significantly lower survival) for Louisiana and South Carolina. After adjustment for other factors, no statistically significant differences in survival were observed for insurance, education, poverty, working class status, urban-rural residence, whether the tumor was screen detected, or digital rectal exam (DRE) results.

With regards to racial disparities, the 2011 Cancer Facts & Figures provides data does demonstrate that African Americans are less likely to survive 5 years after diagnosis of most cancers than white men. However for prostate cancer, the survival rates are similar.

Although survival did not vary by race, treatment modalities do. Radical prostatectomy was the predominant mode of initial treatment for all race/ethnic groups except non-Hispanic other in the PoC1 study. Non-Hispanic white men were least likely to receive conservative management. The proportions of both types of definitive treatment were highest among married men. The overwhelming majority of men in our sample had

private insurance. Men with public insurance were least likely to receive surgical treatment and most likely to receive conservative management. Patients residing in high education census tracts were more apt to have been surgically treated, as were patients residing in non-poverty census tracts and patients in non-working class census tracts. Treatment patterns varied geographically. The proportion of men with clinically localized prostate cancer who underwent radical prostatectomy was highest in Colorado (44.2%) and lowest in New York (34.9%). Receipt of radiation therapy was highest in New York (40.7%) and lowest in California (25.3%). Less absolute variability was observed in the proportion of men who underwent conservative management (range: 26.1% in New York to 32.4% in Illinois).

1b.5 Citations for Data on Disparities Cited in 1b.4: [*For Maintenance* – *Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]
1. http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-027765.pdf
Cancer Facts & Figures 2011-2012 American Cancer Society. Cancer Facts & Figures for African Americans 2011-2012. Atlanta: American Cancer Society, 2011.

2. BMC Cancer. 2010; 10: 152.
Published online 2010 April 19. doi: 10.1186/1471-2407-10-152

3. http://seer.cancer.gov/faststats/selections.php?#Output
http://seer.cancer.gov/faststats/selections.php?#Output
accessed 11/30/11. Site updated 11/10/11

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

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

Quantity	Quality	Consistency	Does the measure pass subcriterion1c?
M-H	**M-H**	**M-H**	**Yes⬤**
L	**M-H**	**M**	**Yes⬤** IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise **No⬤**
M-H	**L**	**M-H**	**Yes⬤** IF potential benefits to patients clearly outweigh potential harms: otherwise **No⬤**
L-M-H	**L-M-H**	**L**	**No ⬤**

Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service	**Does the measure pass subcriterion1c?** **Yes⬤** IF rationale supports relationship

1c.1 Structure-Process-Outcome Relationship (*Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome*)**:**
The ultimate health outcome to be achieved by this measure is the early and appropriate identification of men with relapsed prostate cancer after attempted curative therapy. Local recurrence can be cured by salvage therapy. In addition, the therapy for metastatic disease depends on the burden of metastatic tumor identified. Thus, even treatment for metastatic disease depends on timing of detection. Our measure focus is PSA surveillance at least every 12 months after definitive therapy for localized prostate cancer. The intermediate clinical outcome is early identification of patients who are eligible for additional curative therapy

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

and/or clinical trials for these men. The process by which these men are identified is PSA surveillance performed at least annually. The structure of how this is done is the use of our rule sets.

Our rule sets will identify men with localized prostate cancer treated with definitive, curative therapy more than a year ago. Men who have not had at least an annual PSA level performed will be identified. Our rules identify men who have laboratory evidence of having a PSA performed, men who report having a PSA performed in the past 12 months, and physician documentation that a PSA was performed and reviewed. We will exclude men who have developed or are being treated for metastatic prostate cancer in the measurement timeframe, as well as men with terminal illness. Men who have not had an annual PSA performed receive a reminder to discuss this test with their physicians. Their physicians also receive a letter suggesting the test be performed.

1c.2-3 Type of Evidence (*Check all that apply*)**:**
Clinical Practice Guideline, Other
American Cancer Society Publications, SEER data.

1c.4 Directness of Evidence to the Specified Measure (*State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population*)**:**
There is evidence directly related to the population of focus for this measure. The central topic and population in the cited evidence are men who had localized prostate cancer treated with curative intent with either radiation therapy or radical prostectomy. The measure focus and target population are identical to the populations in the major studies.

1c.5 Quantity of Studies in the Body of Evidence (*Total number of studies, not articles*)**:** We looked at 664 publications (guidelines, studies, abstracts) of this population were identified in the past 5 years. Of these, 349 were applicable to our patient population. Results from 15 of the highest quality studies are referenced in this document.

1c.6 Quality of Body of Evidence (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events*)**:** One of the most compelling studies to demonstrate the survival advantage for salvage radiation therapy for PSA detected relapse after definitive surgery was a retrospective study performed by the Johns Hopkins School of Medicine, published in JAMA in 2008 by Trock et. al . This was a retrospective analysis of 635 US men who underwent prostectomy from 1982-2004 and who had PSA and/or local recurrance.

397 received no salvage therapy, 160 received salvage radiation therapy [RT], and 78 received salvage RT plus hormonal therapy. With a median follow up of 6 years post recurrence, salvage RT was associated with a stastistically 3x increase in prostate cancer-specific survival compared to the observatio arm [hazard ration 0.32, 95% conficence interval 0.19-0.54; P<0.01].

The main flaw of this study is common to all retrospective studies. However, because of the traditional difficultly obtaining durable and meaningul responses to therapy for metastatic prostate cancer, obtaining data from prospective randomized trials of curative therapy vs. observation will not likely be readily available.

Multiple studies have show both a survival and quality of life benefit of for men who are treated with androgen deprivation [castration] therapy when metastatic disease is detected. And in addition, for the first time, new agents have shown a survival benefit for men who fail ADT and are considered castrate-resistant.

Some of these agents are vaccines, such as Sipuleucel-T, which is best given when there is less burden of disease. The pivotal trial was a multicentered phase III randomized, placebo-controlled study of the vaccine involving 512 men [D9902B]. This trial showed a 4 month overal survival benefit. This translates into a 22% decrease in mortality risk [HR 0.78; 95% CI 0.61-0.98; P = 0.03]. Because this is an immunotherapy that works best on paitents without large amounts or rapidly progressing disease, early identification of metastasis is important to receive benefit.

1c.7 Consistency of Results across Studies *(Summarize the consistency of the magnitude and direction of the effect):* The benefit of salvage and metastatic therapy is consistent across most studies.

1c.8 Net Benefit *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms)***:**
Several studies are currently looking at stratifying which patients who have biochemical or clinical relapse after definitive therapy benefit most from specific approaches.

We will be following the outcome of these studies, but final recommendations for intervention will be several years in the future. Our measure will also help ensure men receive appropriate testing which will also enable enrollment into current and future clinical trials designed to address these questions.

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

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: N/A

1c.11 System Used for Grading the Body of Evidence: Other

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

1c.13 Grade Assigned to the Body of Evidence: N/A

1c.14 Summary of Controversy/Contradictory Evidence: None.

1c.15 Citations for Evidence other than Guidelines*(Guidelines addressed below)***:**
1.JAMA. 2008 Jun 18;299(23):2760-9.
Prostate cancer-specific survival following salvage radiotherapy vs observation in men with biochemical recurrence after radical prostatectomy.
Trock BJ, Han M, Freedland SJ, Humphreys EB, DeWeese TL, Partin AW, Walsh PC.

2.American Urological Association Education and Research, Inc. Prostate-specific antigen best practice statement: 2009 update.
Linthicum (MD): American Urological Association Education and Research, Inc.; 2009. 82 p. [264 references]. The Use of PSA in the Post-Treatment Management of Prostate Cancer.

1c.16 Quote verbatim, the specific guideline recommendation *(Including guideline # and/or page #)***:**
Monitoring After Treatment:
For patients initially treated with intent to cure, a serum PSA level should be measured every 6-12 months for the first 5 years and then rechecked annually.

NCCN GuidelinesTM Prostate Cancer V4.2011 Page MS-18
www.nccn.org/professionals/physician_gls/pdf/prostate.pdf

1c.17 Clinical Practice Guideline Citation: NCCN GuidelinesTM Prostate Cancer V4.2011. Referenced with permission. The NCCN Guidelines and illustrations within may not be reproduced in any form for any purpose without the express written permission of the NCCN © 2011 National Comprehensive Cancer Network. To view the most recent and complete version of the NCCN Guidelines, go online to NCCN.org.

1c.18 National Guideline Clearinghouse or other URL:
www.nccn.org/professionals/physician_gls/pdf/prostate.pdf

1c.19 Grading of Strength of Guideline Recommendation. Has the recommendation been graded? Yes

1c.20 If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: The body of evidence has been graded by The National Comprehensive Cancer Centers Network. The prostate cancer panel has 30 members. The panel has representation from Radiation Oncology, Urology, Medical Oncology, Supportive Care, Palliative Care, Paim Management, Pastoral Care, Oncology Social Work, and Patient Advocacy.

1c.21 System Used for Grading the Strength of Guideline Recommendation: GRADE

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

1c.23 Grade Assigned to the Recommendation: Grade 2A

1c.24 Rationale for Using this Guideline Over Others: The NCCN GuidelinesTM remain the most comprehensive and widely used treatment and follow up guidelines for practitioners treating and following cancer patients.

Based on the NQF descriptions for rating the evidence, what was the <u>developer's assessment</u> of the quantity, quality, and consistency of the body of evidence?
1c.25 Quantity: High   **1c.26** Quality: High**1c.27** Consistency**:** High
1c.28 Attach evidence submission form**:**
1c.29 Attach appendix for supplemental materials**:**

Was the threshold criterion, *Importance to Measure and Report*, met?
(*1a & 1b must be rated moderate or high and 1c yes*)   Yes⦿ No⦿
Provide rationale based on specific subcriteria:

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

2. RELIABILITY & VALIDITY - SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **(evaluation criteria)**
Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See guidance on measure testing.

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

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

S.2 If yes, provide web page URL: www.activehealth.com/nqf-measures-with-articles

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

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

2a1.1 Numerator Statement (*Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome*):
Men who had at least one PSA level in the past 12 months.

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

2a1.3 Numerator Details (*All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, codes with descriptors, and/or specific data collection items/responses*):
(NOTE: Words written in capital letters are element names. Please refer to the code set in the attachment for description.)

One of the following:
1.Presence of at least 1 PROSTATE CANCER WORK UP procedure code in the past 12 months
2.Presence of at least 1 PROSTATE PELVIS BLADDER MRI (ICD9) diagnosis in the past 12 months.
3.Presence of at least 1 ELEVATED PSA diagnosis in the past 12 months
4.Presence of at least 1 PSA CPT procedure in the past 12 months
5.Presence of at least 1 MU PSA   lab results (value) in the past 12 months
6.Presence of patient data confirming at least 1 PDD- PSA SURVEILLANCE 1 YEAR OBSERVED results in the past 12 months.

2a1.4 Denominator Statement (*Brief, narrative description of the target population being measured*):
Men with localized prostate cancer who were treated with curative intent.

2a1.5 Target Population Category (*Check all the populations for which the measure is specified and tested if any*): Populations at Risk

2a1.6 Denominator Time Window (*The time period in which cases are eligible for inclusion*):
Anytime in the past months (note: except PDD, Health Information Exchange and disability data).

2a1.7 Denominator Details (*All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses*):
(NOTE: Words written in capital letters are element names. Please refer to the code set in the attachment for description.)

One of the following:
1. Presence of at least 1 CANCER PROSTATE   diagnosis overlapping within 30 days with PROSTATE CANCER SURGERY procedure in the past anytime prior to the last 12 months.
2. Presence of at least 1 CANCER PROSTATE   diagnosis overlapping within 30 days with PROSTATE CA RADIATION RX procedure in the past anytime prior to the last 12 months.
3. Presence of at least 1 NON-METASTATIC PROSTATE CANCER STAGE (CPT/HCPCS) procedure overlapping within 30 days with PROSTATE CANCER SURGERY procedure in the past anytime prior to the last 12 months.
4. Presence of at least 1 NON-METASTATIC PROSTATE CANCER STAGE (CPT/HCPCS) procedure

overlapping within 30 days with PROSTATE CA RADIATION RX procedure in the past anytime prior to the last 12 months.

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)***:**
1. Surgical treatment for prostate cancer in the past year
2. Drug treatment for prostate cancer in the past year
3. Radiation therapy for prostate cancer in the past year
4. Prostate MRI in past year
5. Prostate biopsy in the past year
6. Metastatic prostate cancer
7. Provider or patient feedback stating patient does not have a diagnosis of prostate cancer.
8. General exclusions
  a. Terminal Illness
  b. Active treatment of malignancy (chemotherapy or radiation therapy) in the past 6 months.
  c. Patients who were admitted to a skilled nursing facility in the past 3 months.

2a1.9 Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)***:**
(NOTE: Words written in capital letters are element names. Please refer to the code set in the attachment for description.)

One of the following:

1. Presence of at least 1 METASTATIC PROSTATE CANCER HCPCS procedure anytime in the past.
2. Presence of at least 1 ORCHIECTOMY BILATERAL procedure overlapping within 30 days with CANCER PROSTATE diagnosis in the past 12 months.
3. Presence of at least 1 PROSTATE CANCER DRUGS procedure within the last 12 months.
4. Presence of at least 1 refill for a PROSTATE CANCER DRUG TREATMENT in the past 12 months.
5. Presence of at least 1 CANCER PROSTATE   diagnosis overlapping within 30 days with PROSTATE CANCER SURGERY procedure in the past 12 months.
6. Presence of at least 1 CANCER PROSTATE   diagnosis overlapping within 30 days with PROSTATE CA RADIATION RX procedure in the past 12 months.
7. Presence of at least 1 NON-METASTATIC PROSTATE CANCER STAGE (CPT/HCPCS)   procedure overlapping within 30 days with PROSTATE CANCER SURGERY procedure in the past 12 months.
8. Presence of at least 1 NON-METASTATIC PROSTATE CANCER STAGE (CPT/HCPCS)   procedure overlapping within 30 days with PROSTATE CA RADIATION RX procedure in the past 12 months.

2a1.10 Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses)***:**
This specific measure addresses all men with a history of a diagnosis of prostate cancer who were treated with curative intent, across the entire measured population. Using our highly specific rule algorithms, people with a history of a diagnosis of prostate cancer who were treated with curative intent will be included in the denominator. Therefore, no risk adjustment or risk stratification is necessary for this unique measure.

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

2a1.13 Statistical Risk Model and Variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.)***:**
No risk adjustment is done with our measures, therefore, we do not have a risk model.

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

2a1.17-18. Type of Score: Rate/proportion

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

2a1.20 Calculation Algorithm/Measure Logic(*Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.*)**:**
Calculation algorithm is included in the attachment for section 2a1.21.

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:
Attachment
NQF MEASURE 0625 RULES.pdf

2a1.24 Sampling (Survey) Methodology. If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)**:**
This measure does not require a sampling or a survey.

2a1.25 Data Source (*Check all the sources for which the measure is specified and tested*). If other, please describe**:**
 Administrative claims, Electronic Clinical Data, Healthcare Provider Survey, Patient Reported Data/Survey

2a1.26 Data Source/Data Collection Instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*)**:** Our data is collected from a number of electronic sources, e.g. health plans, pharmacy-based management systems, electronic health records, etc. Data may be collected in various forms. We accept claims from pharmacies, labs, third-party payors, hospitals, physicians, etc. Patient-derived data is gathered by our nurses, lifestyle coaches, and nutritionists through our disease management program (Active Disease Management), lifestyle coaching program (Active Lifestyle Coaching), and maternity program (Active Maternity Management), as well as through our electronic patient health record (myActiveHealth). Data may also be entered by clinicians and their extenders through our online physician portal (Active Care Team Suite).

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment: URL
https://www.activehealthphrpp.net/PortalDemo/PortalLogin.aspx
Username: PHRDemo181 / Password: Testing456

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:
Attachment
NQF Measure 0625 Codes.pdf

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested*)**:**
Clinician : Group/Practice, Clinician : Individual, Facility, Health Plan, Population : County or City, Population : National, Population : State

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

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

2a2.1 Data/Sample (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*)**:**
All the data for the measures are obtained from electronic sources. Based on the client, we take in administrative claims data, pharmacy-based management systems, laboratory systems, personal health records, health risk assessments, and electronic health records. In addition, we use data from care management systems. All data feeds are electronic and do not require manual medical chart abstraction.

We have over 20 million patient records in our database, consisting of data from provider organizations, hospital systems, healthcare plans, Medicare and Medicaid. The average age of the population is 37 years(range 12 – 77) and 51% of the population is female. We tested the reliability of the data on a population of 279,666 patients from a major health plan. The average age of the population was 35 years and 52% were female. The data abstraction was performed in 2011.

2a2.2 Analytic Method (*Describe method of reliability testing & rationale*)**:**
All of our quality measures are electronic and all of the data used to support the measures are electronic. In addition, we receive the data by electronic feeds. We have internal processes to ensure that we receive valid codes and where appropriate the associated values. Our analytic process includes testing a new rule or algorithm on our test database of 2 million patient records, so that we can be sure of the reliability of the code. At the end of the test, we randomly select patients who are either in the numerator or in the denominator but not the numerator, and review their individual electronic data to ensure that they met the requirements of the rule. As a part of our reliability testing, we check to ensure that we have found the correct people in the denominator or the numerator, across multiple rules with similar definitions. To ensure accuracy, we check a subset of the people who were not in the numerator to ensure that we were accurate in not counting them in the numerator. If we find errors at any stage of the reliability testing, e.g., similar denominators that had significant differences in counts, different compliance rates for similar populations; we update the rules and retest.

2a2.3 Testing Results (*Reliability statistics, assessment of adequacy in the context of norms for the test conducted*)**:**
Below are the descriptive statistics for the data sources of the test population:

1. The proportion of patients within each client group with diagnosis/procedure claims in the last 365 days was: median 53% (IQR = 10%).
2. The proportion of patients within each client group with at least 1 prescription in the last 365 days was: median 81% (IQR = 8%).
3. The proportion of patients within each client group with lab results in the last 365 days was: median 46% (IQR = 12%).

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

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

differences from the evidence:
The focus for this particular measure is highly consistent with the evidence cited.

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

2b2.1 Data/Sample (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):
All the data for the measures are obtained from electronic sources. Based on the client, we take in administrative claims data, pharmacy-based management systems, laboratory systems, personal health records, health risk assessments, and electronic health records. In addition, we can take in data from care management systems. All data feeds are electronic and do not require manual medical chart abstraction.

We have over 20 million patient records in our database, consisting of data from provider organizations, hospital systems, healthcare plans, Medicare and Medicaid. The average age of the population is 37 years(range 12 – 77) and 51% of the population is female. We tested the validity of the data on a population of 279,666 patients from a major health plan. The average age of the population was 35 years and 52% were female. The data abstraction was performed in 2011.

2b2.2 Analytic Method (*Describe method of validity testing and rationale; if face validity, describe systematic assessment*):
All of our quality measures are electronic and all the data used to support the measures are electronic. In addition, we receive the data by electronic feeds. We have internal processes to ensure that we receive valid codes and where appropriate the associated values. Currently we use a database of approximately 2 million patient records for testing purposes. Our analytic process includes testing a new rule or algorithm on the standard data set so that we can be sure of the reliability of the code. At the end of the test, we randomly select patients who are either in the numerator, or in the denominator but not the numerator, to ensure that they met the requirements of the rule. As a part of our validity testing, we check to ensure we have found the correct people in the denominator or the numerator. To ensure accuracy, we check a subset of the people who were not in the numerator to ensure that we were accurate in not counting them in the numerator. If we find errors at any stage we update the rules and retest.
Further, to ensure that we obtain valid results once the measures are deployed, when we run the measure for a client we evaluate the results to ensure they are consistent with what we have found in the past for the client and across our book of business.
This year, we added ICD 10 codes to our already robust code sets. A team of analysts performed a concise mapping of ICD 9 codes to their respective ICD 10 codes. A group of clincians from the Clinical Research and Development team reviewed the results of this mapping for accuracy.
This year, we added ICD 10 codes to our already robust code sets. A team of analysts performed a concise mapping of ICD 9 codes to their respective ICD 10 codes. A group of clincians from the Clinical Research and Development team reviewed the results of this mapping for accuracy. The ICD 10 code sets were emailed to the NQF Measures Maintenance Director, Glyndon Morris, on February 24, 2012 separately from our traditional code sets (which were uploaded in Section 2a 1.30)

2b2.3 Testing Results (*Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment*):
The algorithms and code sets used for the measures are all electronic. Once we test the rules, the results are reviewed by our clinical research and development committee, composed of physicians of varying specialties, pharmacists, and nurses. After the rules are deployed in a production environment for our clients, the rule is considered reliable, i.e., we have found the appropriate people in the denominator and numerator.

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

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

2b3.1 Data/Sample for analysis of exclusions (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*)**:**
All the data for the measures are obtained from electronic sources. Based on the client, we take in administrative claims data, pharmacy-based management systems, laboratory systems, personal health records, health risk assessments, and electronic health records. In addition, we can take in data from care management systems. All data feeds are electronic and do not require manual medical chart abstraction.

We have over 20 million patient records in our database, consisting of data from provider organizations, hospital systems, healthcare plans, Medicare and Medicaid. The average age of the population is 37 years(range 12 – 77) and 51% of the population is female. We tested the exclusion criteria of the measure on a population of 279,666 patients from a major health plan. The average age of the population was 35 years and 52% were female. The data abstraction was performed in 2011.

2b3.2 Analytic Method (*Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference*)**:**
We exclude patients who had metastatic prostate cancer anytime in the past OR had prostate cancer in the past 12 months treated with either a) bilateral orhiectomy, b) surgery, c) radiotherapy, or d) prostate cancer medications. Our exclusions are tested and analyzed using the same methodology as for our numerator and denominator.

2b3.3 Results (*Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses*):
We do not perform statistical analysis for our exclusions. We manually review our electronic processes to ensure accuracy of our exclusions.

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

2b4.1 Data/Sample (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*)**:**
This specific measure addresses all men with a history of a diagnosis of prostate cancer who were treated with curative intent, across the entire measured population. Using our highly specific rule algorithms, people with a history of a diagnosis of prostate cancer who were treated with curative intent will be included in the denominator. Therefore, no risk adjustment or risk stratification is necessary for this unique measure.

2b4.2 Analytic Method (Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables*)**:**
This specific measure addresses all men with a history of a diagnosis of prostate cancer who were treated with curative intent, across the entire measured population. Using our highly specific rule algorithms, people with a history of a diagnosis of prostate cancer who were treated with curative intent will be included in the denominator. Therefore, no risk adjustment or risk stratification is necessary for this unique measure.

2b4.3 Testing Results (*Statistical risk model: Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata*)**:**
This specific measure addresses all men with a history of a diagnosis of prostate cancer who were treated with curative intent, across the entire measured population. Using our highly specific rule algorithms, people with a history of a diagnosis of prostate cancer who were treated with curative intent will be included in the denominator. Therefore, no risk adjustment or risk stratification is necessary for this unique measure.

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment: This specific measure addresses all men with a history of a diagnosis of prostate cancer who were treated with curative intent, across the entire measured population. Using our highly specific rule algorithms, people with a history of a diagnosis of prostate cancer who were treated with curative intent will be included in the denominator. Therefore, no risk adjustment or risk stratification is necessary for this unique measure.

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

2b5.1 Data/Sample (*Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*)**:**
We have over 20 million patient records in our database, consisting of data from provider organizations, hospital systems, healthcare plans, Medicare and Medicaid. The average age of the population is 37 years (range 12 – 77) and 51% of the population is female. Of these, 39,386 patients fulfilled the denominator criteria, and the compliance rate was 80%. Data abstraction was performed in 2011.

2b5.2 Analytic Method (*Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance*)**:**
Differences in performance between clients are related to the characteristics of specific client populations. For example running this measure on a young population, may result in a lower denominator and compliance rate, compared to evaluating the measure across an older population.

2b5.3 Results (*Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance*):
 Measure performance results across 106 client populations for this measure (N = 39,386):

10th percentile = 58%
25th percentile = 75%
50th percentile = 83%
75th percentile = 88%
90th percentile = 100%

Interquartile range = 13%

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

2b6.1 Data/Sample (*Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*)**:**
We receive electronic data from multiple sources – health plan, electronic health record, personal health record, etc. Independent of the sources, all the available data about a patient are aggregated into a single patient record for use in performance measurement. Therefore, for an individual patient the record may include claims data, clinical data from an electronic health record, or self-reported data from a patient health record. Based on this, we do not typically conduct analyses based on disparate sources of data. Instead, the rules contain redundancies to accommodate the different sources of data or the absence of specific data based on the source. Therefore, this measure has not been compared across data sources.

2b6.2 Analytic Method (*Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure*)**:**
We ingest data from multiple sources (e.g., diagnosis, procedure, lab, pharmacy claims, clinical data, patient derived data, provider feedback). Using a complex and highly specific rule algorithm, we are able to ensure that the various data sources are appropriately weighted, based on the consensus of our clinical

research and development committee. Therefore, this measure has not been compared across data sources.

2b6.3 Testing Results *(Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted)***:**
This measure has not been compared across data sources.

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

2c.1 If measure is stratified for disparities, provide stratified results *(Scores by stratified categories/cohorts)***:** This specific measure addresses all men with a history of a diagnosis of prostate cancer who were treated with curative intent, across the entire measured population and is not stratified for disparities.

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:
Our goal with this specific measure is to identify those providers who have ordered a PSA diagnostic test to all of their patients with prostate cancer regardless of age, race or socio-economic status.

2.1-2.3 Supplemental Testing Methodology Information:

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

If the Committee votes No, STOP

3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (**evaluation criteria**)

C.1 Intended Actual/Planned Use *(Check all the planned uses for which the measure is intended)***:** Public Reporting, Quality Improvement (Internal to the specific organization)

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

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

3a.1. Use in Public Reporting - disclosure of performance results to the public at large *(If used in a public reporting program, provide name of program(s), locations, Web page URL(s)).* <u>If not publicly reported in a national or community program</u>, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: **[*For Maintenance – *** *If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.***]**
Our measure specifications including numerator, denominator and exclusion descriptions, algorithms, and code sets are publicly available at the following URL address: www.activehealth.com/nqf-measures-with-

articles (Username: activehealth ; Password: AH$1@2)
The results of each measure are client specific. Due to the private nature of these results, we leave it to each client's individual discretion to release their results publicly.

3a.2.Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results**: In terms of the 2011 incidence data from the American Cancer Society, prostate cancer is the common cancer in men in the United States. It is the second most common cause of cancer deaths in men, with as estimated 33,700 cases in 2011, accounting for 11% of all cancers. Although screening for prostate cancer and the decision of when and who to treat remains controversial, appropriate follow-up for those men who have already received definitive therapy [therapy with curative intent] is not.

Our 2011 data identified that 20% of patients with a history of a diagnosis of prostate cancer who were treated with curative intent did not have a PSA level in the past 12 months. Men who have relapsed after definitive therapy are clearly at risk for dying of prostate cancer. Early detection and appropriate therapy is key to curing those who still have a chance for salvage curative therapy, as well as determining choice of therapy for those who are not candidates for salvage cure.

3.2 Use for other Accountability Functions (payment, certification, accreditation). If used in a public accountability program, provide name of program(s), locations, Web page URL(s)**: We do not use our measures for other accountability functions at this time.**

3b. Usefulness for Quality Improvement: H⊙ M⊙ L⊙ I ⊙
(*The measure is meaningful, understandable and useful for quality improvement.*)

3b.1. Use in QI. If used in quality improvement program, provide name of program(s), locations, Web page URL(s):
[**For _Maintenance_ –** *If not used for QI, indicate the reasons and describe progress toward using performance results for improvement*].
This measure is used in quality improvement programs internal to a specific organization, e.g., our individual clients. Our clients are able to use our measure performance results to increase awareness and improve compliance.

3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement. If usefulness was demonstrated *(e.g., QI initiative),* describe the data, method and results:
In terms of the 2011 incidence data from the American Cancer Society, prostate cancer is the common cancer in men in the United States. It is the second most common cause of cancer deaths in men, with as estimated 33,700 cases in 2011, accounting for 11% of all cancers. Although screening for prostate cancer and the decision of when and who to treat remains controversial, appropriate follow-up for those men who have already received definitive therapy [therapy with curative intent] is not.

Our 2011 data identified that 20 percent of patients with a history of a diagnosis of prostate cancer who were treated with curative intent did not have a PSA level in the past 12 months. Men who have relapsed after definitive therapy are clearly at risk for dying of prostate cancer. Early detection and appropriate therapy is key to curing those who still have a chance for salvage curative therapy, as well as determining choice of therapy for those who are not candidates for salvage cure.

Overall, to what extent was the criterion, *Usability*, met? H⊙ M⊙ L⊙ I ⊙
Provide rationale based on specific subcriteria:

4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (**evaluation criteria**)

4a. Data Generated as a Byproduct of Care Processes: H⊙ M⊙ L⊙ I ⊙

4a.1-2 How are the data elements needed to compute measure scores generated? *(Check all that apply).*
Data used in the measure are**:**
generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Other
We are able to ingest and process self-reported patient data, data from disease management programs, and data from providers.

4b. Electronic Sources: H⊙ M⊙ L⊙ I ⊙

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

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

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

4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:
We use a combination of data sources to mitigate the risk of inaccuracies or errors. We recognize that generally, electronic data have inherent errors and inaccuracies related to incorrect coding, or missing data, which can result in less specificity in the definition of the denominator and /or the numerator. To minimize these errors and inaccuracies, we use clinically enriched data (laboratory results, medication lists) to augment the data. In addition, where possible, we corroborate the data. For example, to confirm a patient has diabetes, we not only confirm the presence of an ICD-9 code for diabetes from claims, we also substantiate this finding with the presence of diabetic medications. We have a mechanism in place to solicit feedback from providers via a feedback form, if they detect errors with the measure.
We do not anticipate significant unintended consequences from the implementation of this measure. Our measures are all developed from evidence-based literature or from clinical practice guidelines and are designed to encourage appropriate care of the patient.

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

A.2 Please check if either of the following apply (*regarding proprietary measures*)**:** Proprietary measure
4d.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues *(e.g., fees for use of proprietary measures)***:**
Providers prefer to have a mechanism to provide feedback, and that our algorithms minimize the risk of false positives. Consequently, we allow the ingest of provider feedback in our rule algorithms, which err on the side of specificity. We have also learnt to be flexible to take in data from all available sources.

Overall, to what extent was the criterion, *Feasibility*, met? H⊙ M⊙ L⊙ I ⊙
Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

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

If the Committee votes No, STOP.
If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

5. COMPARISON TO RELATED AND COMPETING MEASURES

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

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

5a. Harmonization

5a.1 If this measure has EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized?

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

5b. Competing Measure(s)

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

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): ActiveHealth Management, 1333 Broadway, 4th Floor, New York, New Hampshire, 10018

Co.2 Point of Contact: Madhavi, Vemireddy, mvemireddy@activehealth.net, 212-651-8200-

Co.3 Measure Developer if different from Measure Steward: Active Health Management, 1333 Broadway, 4th Floor, New York, New York, 10018

Co.4 Point of Contact: Lindee, Chin, MD, lchin@activehealth.net, 212-590-2674-

Co.5 Submitter: Rajesh, Mehta, R.Ph., MS., rmehta@activehealth.net, 212-651-8200-, ActiveHealth Management

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

Co.7 Public Contact: Rajesh, Mehta, R.Ph., MS, rmehta@activehealth.net, 212-651-8200-, ActiveHealth

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

Management

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development
Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

Bani Vir, MD: Medical Director, Clinical Research & Development, ActiveHealth Management, Inc.
Lindee Chin, MD: Medical Director, Clinical Research & Development, ActiveHealth Management, Inc.
Ajay Sharma, MD: Medical Director, Clinical Research & Development, ActiveHealth Management, Inc.
George Wu, MD: Medical Director, Clinical Research & Development, ActiveHealth Management, Inc.
Flora Chang, PharmD, Director of Pharmacy Informatics, Clinical Research & Development, ActiveHealth Management.
Rajesh R. Mehta, R.Ph., MS, Director of Pharmacy Informatics, Clinical Research & Development, ActiveHealth Management.

ActiveHealth Management measures are developed by our Quality Measures Management Committee, a division of the Clinical Research and Development Department, composed of physicians of varying specialties and pharmacists. This committee evaluates available clinical evidence guidelines, reliability of data from various sources, and the necessity to develop measures to help improve standards of healthcare.

Ad.2 If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward:

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.3 Year the measure was first released: 2007
Ad.4 Month and Year of most recent revision: 12, 2011
Ad.5 What is your frequency for review/update of this measure? Annual
Ad.6 When is the next scheduled review/update for this measure? 12, 2012

Ad.7 Copyright statement: This information, including any attachments hereto, is the sole, exclusive, proprietary and confidential property of ActiveHealth Management, Inc., and is for the exclusive use of The National Quality Forum. Any use, copying, disclosure, dissemination or distribution by anyone other than the National Quality Forum is strictly prohibited.

Ad.8 Disclaimers:

Ad.9 Additional Information/Comments: Username and Password for the URL listed in "Specifications" section of this submission:
URL: www.activehealth.com/nqf-measures-with-articles

Username: activehealth
Password: AH$1@2

Date of Submission (*MM/DD/YY*): 10/03/2011