



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 |
|---|
| <p>NQF #: 0045</p> <p>Corresponding Measures:</p> <p>De.2. Measure Title: Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older</p> <p>Co.1.1. Measure Steward: National Committee for Quality Assurance</p> <p>De.3. Brief Description of Measure: Percentage of adults 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication.</p> <p>1b.1. Developer Rationale: This measure aims to improve the communication and coordination from the physician treating the fracture in the acute care setting to the physician or clinician who is responsible for follow-up care for osteoporosis. Patients who experience a fragility fracture should either be treated or screened for the presence of osteoporosis. Although the fracture may be treated by the orthopedic surgeon, the testing and/or treatment is likely to be under the responsibility of the physician providing on-going care. It is important the physician or other clinician providing on-going care for the patient be made aware the patient has sustained a fracture so that the proper care and treatment plan can be put in place to prevent a secondary fracture from occurring. This measure holds the physician who treated the fracture accountable for this communication to the on-going care provider.</p> |
| <p>S.4. Numerator Statement: Patients with documentation of communication with the physician or other clinician managing the patient's on-going care that a fracture occurred and that the patient was or should be considered for osteoporosis testing or treatment.</p> <p>Communication may include documentation in the medical record indicating that the clinician treating the fracture communicated (e.g., verbally, by letter, through shared electronic health record, a bone mineral density test report was sent) with the clinician managing the patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.</p> <p>S.6. Denominator Statement: Adults aged 50 years and older who experienced a fracture, except fractures of the finger, toe, face or skull.</p> <p>S.8. Denominator Exclusions: Exclude members who use hospice services during the measurement period.</p> |
| <p>De.1. Measure Type: Process</p> <p>S.17. Data Source: Electronic Health Records, Paper Medical Records</p> <p>S.20. Level of Analysis: Clinician : Group/Practice, Clinician : Individual</p> |
| <p>IF Endorsement Maintenance – Original Endorsement Date: May 01, 2007 Most Recent Endorsement Date: Dec 30, 2014</p> |
| <p>IF this measure is included in a composite, NQF Composite#/title:</p> <p>IF this measure is paired/grouped, NQF#/title:</p> <p>De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?</p> |

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

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

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

1b. Performance Gap

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

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

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

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

This measure aims to improve the communication and coordination from the physician treating the fracture in the acute care setting to the physician or clinician who is responsible for follow-up care for osteoporosis. Patients who experience a fragility fracture should either be treated or screened for the presence of osteoporosis. Although the fracture may be treated by the orthopedic surgeon, the testing and/or treatment is likely to be under the responsibility of the physician providing on-going care. It is important the physician or other clinician providing on-going care for the patient be made aware the patient has sustained a fracture so that the proper care and treatment plan can be put in place to prevent a secondary fracture from occurring. This measure holds the physician who treated the fracture accountable for this communication to the on-going care provider.

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

The following data are extracted from Physician Quality Reporting System (PQRS) and reflect data for services provided from January 1, 2012 through December 31, 2012. Currently PQRS is a pay-for-reporting incentive program that allows providers to choose which quality measures to report on. In 2012, of 204,349 eligible providers, only 0.4% chose to report on this measure. Therefore, the performance rates below are reflective of less than one percent of Medicare providers.

Performance data is summarized at the physician level and described by mean, 10th, 25th, 50th, 75th and 90th percentile.

Performance Rate for all Reporting Providers

Mean | 10th | 25th | 50th | 75th | 90th
62.7% | 0.00% | 0.00% | 0.00% | 100% | 100%

Average performance rates from 2009-2011

2009 | 49.0%
2010 | 50.6%
2011 | 62.4%

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

N/A

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

CMS does not currently report performance data stratified by different variables in the PQRS program, where the measure is in use.

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

People of all ethnic backgrounds are at risk of osteoporosis; however, non-Hispanic Caucasian and Asian women 50 and older have a higher prevalence of osteoporosis (20 percent), compared with Hispanic (10 percent) and non-Hispanic African American (5 percent) populations (NOF, 2013). Similarly, hip fracture rates are highest for non-Hispanic Caucasian women (140.7 per 100,000) and Asian women (85.4 per 100,000), but still prevalent in African American women (57.3 per 100,000) and Hispanic women (49.7 per 100,000) (Silverman, 1988).

There is a misconception that osteoporosis is only a concern for non-Hispanic white women, which may result in delaying prevention and treatment in non-White and Hispanic populations. African-American and Hispanic women are less likely to believe they are at risk for osteoporosis (NIH NIAMS 2010). A study based on a large managed care organization found ethnic and racial minority patients are 2-3 times less likely to be offered osteoporosis screening or treatment compared to White women (Thomas 2007). Prevention efforts should target all women, irrespective of their race/ethnicity (Cauley 2011).

Research suggests that African American women receive less dual-energy x-ray absorptiometry screenings and treatment for osteoporosis. One study found that 30% (21% received test) of African American women were referred to dual-energy x-ray absorptiometry tests compared to 38% (27% received test) of Caucasian women. In addition, for those women who had a confirmed diagnosis of osteoporosis, 78% of African American were likely to receive a medication compared to 89% of Caucasians (Hamrick, 2012). An earlier study with a smaller sample size found that of those diagnosed with osteoporosis, 62% of African Americans were started on a treatment compared to 83% of Caucasian women (Hamrick, 2006).

Cauley, J. (2011). Defining Ethnic and Racial Differences in Osteoporosis and Fragility Fractures. *Clinical Orthopaedics & Related Research*; 469(7):1891-9.

Hamrick I, Cao Q, Agbafé-Mosley D, Cummings DM. Osteoporosis healthcare disparities in postmenopausal women. *J Womens Health (Larchmt)*. 2012 Dec; 21 (12):1232-6. Doi: 10.1089/jwh.2012.3812. Epub 2012 Nov 9.

Hamrick, I, Whetsone LM, Cummings DM. Racial disparity in treatment of osteoporosis after diagnosis. *Osteoporos Int*. 2006;17 (11): 1653-8. Epub 2006 Jul 27.

Silverman, S.L., R.E. Madison. 1988. Decreased incidence of hip fracture in Hispanics, Asians, and blacks: California Hospital Discharge Data. *Am J Public Health*. 78:1482–83.

Thomas, P. Racial and Ethnic Differences in Osteoporosis. *J Am Acad Orthop Surg*, Vol 15, No suppl_1, September 2007, S26-S30. National Institutes of Health. National Institute of Arthritis and Musculoskeletal and Skin Disorders. Osteoporosis and African American Women. June 2010. Accessed at: www.niams.nih.gov/hi/topics/osteoporosis/opbkgr.htm

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):

Endocrine, Musculoskeletal, Musculoskeletal : Osteoporosis

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

Care Coordination, Primary Prevention

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

Elderly, Populations at Risk

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

N/A

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

This is not an eMeasure Attachment:

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

Attachment Attachment: 0045_Fractures_Value_Set-636265546355440193.xlsx

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

Attachment:

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

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.

Yes

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.

Added hospice exclusion.

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 with documentation of communication with the physician or other clinician managing the patient's on-going care that a fracture occurred and that the patient was or should be considered for osteoporosis testing or treatment.

Communication may include documentation in the medical record indicating that the clinician treating the fracture communicated (e.g., verbally, by letter, through shared electronic health record, a bone mineral density test report was sent) with the clinician managing the patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.

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).

Patients with documentation of communication with the physician or other clinician managing the patient's on-going care that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing.

The numerator criteria is met by documentation in the medical record of communication (e.g., verbal, by letter, through shared electronic health record, or a bone mineral density test report was sent) that a fracture occurred and that the patient was or should be tested or treated for osteoporosis. This measure is also collected in the Quality Payment Program using a CPTII code specific to the quality measure:

- CPT Category II code: 5015F-Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

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

Adults aged 50 years and older who experienced a fracture, except fractures of the finger, toe, face or skull.

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).

Adults who had a documented patient encounter (See Table 1 for encounter codes) with a fracture diagnosis (See Fracture Value Set). See S.2b. (Data Dictionary Code Table) for all value sets.

Table 1: Patient encounter during the reporting period (CPT):

Services codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

Procedure codes: 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22510, 22511, 22513, 22514, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

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

Exclude members who use hospice services during the measurement period.

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.)

Exclude patients who had for hospice services (G9688) during the measurement period.

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.)

N/A

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

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (*Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.*)

Step 1: Determine the eligible population. To do so, identify patients who meet all the specified criteria.

-Age: 50 years and older

-Patient encounter during the reporting period (12 months) with a diagnosis of fracture

Step 2: Identify the number of patients who had documentation of communication with the physician or clinician managing the patient's on-going care that a fracture occurred and the patient was or should be considered for osteoporosis testing or treatment.

Step 3: Calculate the rate (The number of patients who had documentation of communication divided by the number of patients who had a fracture).

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

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

N/A

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

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

N/A

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

If other, please describe in S.18.

Electronic Health Records, Paper Medical Records

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

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

This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to patients to identify the numerator. In the PQRS program this measure is coded using CPT II codes specific to quality measurement.

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*)

No data collection instrument provided

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*)

Inpatient/Hospital, Outpatient Services

If other:

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

N/A

2. Validity – See attached Measure Testing Submission Form

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the

testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

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

2.3 For maintenance of endorsement

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

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 or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

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**.

Some data elements are in defined fields in electronic sources

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).

To allow for widespread reporting across physicians and clinical practices, this measure is collected through multiple data sources (administrative data, electronic clinical data, and paper records). An e-specification of this measure is currently in development.

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

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs

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

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

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

Feedback on use of this measure in CMS PQRS program has been positive with few questions raised by participating clinicians to the CMS vendor. NCQA works with the CMS vendor to review any questions or issues raised with the measure on a bi-weekly basis.

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

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

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. Current and Planned Use

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

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

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

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

PHYSICIAN QUALITY REPORTING SYSTEM: This measure is used in the Physician Quality Reporting System (PQRS) which is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals. Eligible professionals who satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer) receive these payment incentives and adjustments. Medicare Part C—Medicare Advantage beneficiaries are not included in claims-based reporting of individual measures or measures groups.

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

N/A

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

N/A

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

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

NA

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

NA

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

Describe how feedback was obtained.

NA

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

NA

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

NA

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

NA

Improvement

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

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

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

N/A

4b2. Unintended Consequences

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

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

No unintended negative consequences were identified during testing. No unintended negative consequences have been reported

since this measure's implementation.

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

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

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

Yes

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

0037 : Osteoporosis Testing in Older Women (OTO)

0046 : Screening for Osteoporosis for Women 65-85 Years of Age

0053 : Osteoporosis Management in Women Who Had a Fracture

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

The following two measures are currently under review for NQF endorsement:

2416: Laboratory Investigation for Secondary Causes of Fracture

2417: Risk Assessment/Treatment After Fracture

The measure steward for these two measures is The Joint Commission

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

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

Are the measure specifications harmonized to the extent possible?

No

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

There are multiple measures of osteoporosis prevention and management. In the most recent update, we undertook a comprehensive harmonization exercise to align several NQF-endorsed osteoporosis measures where possible given the different measure focus, methods of data collection and level of accountability. Below we describe the harmonization between this measure (0045) and the most closely related measures, 0037, 0046, 0053, 2416, 2417. Please see the attached memo on alignment of measures for a more in-depth description of the NCQA harmonization efforts. NCQA OWNED RELATED MEASURES: 0037: Osteoporosis Testing in Older Women & 0046: Screening for Osteoporosis for Women 65-85 Years of Age. Measures 0037 and 0046 assess the number of women 65-85 who report ever having received a bone density test to check for osteoporosis. These measures focus on screening for osteoporosis in the general population, whereas measure 0045 is focused on communication between the physician who treated the fracture and the provider who is responsible for managing the patient's care post fracture. Therefore, we consider these measures to be related but not competing. The differences between these two measures are reflective of the different guidelines for general population screening and second prevention. Where it is appropriate to the measure focus and evidence, we have aligned the measures. 0053: Osteoporosis Management in Women Who Had a Fracture. Measure 0053 looks at the percentage of women age 50 and older who experience a fracture and receive either a bone mineral density test to check for osteoporosis or treatment for osteoporosis. The intent of measure 0053 is to determine if screening or treatment occurred, whereas measure 0045 is focused on whether communication between providers took place so screening and treatment could be initiated. Therefore, we consider these measures to be related but not competing. The differences between these two measures

are reflective of the different measure intents. Where it is appropriate to the measure focus and evidence, we have aligned the measures. We believe these two measures are complementary showing provider quality of care along multiple points along the continuum of care post-fracture. OTHER RELATED MEASURES: 2416: Laboratory Investigation for Secondary Causes of Fracture. Measure 2416 (currently under review for NQF endorsement) assesses the percentage of patients age 50 and over who had a fragility fracture and had the appropriate laboratory investigation for secondary causes of fracture ordered or performed prior to discharge from an inpatient hospitalization. This measure has a different focus from measure 0045 (identifying cause of fracture as opposed to communication and care coordination around fracture). While the target population of this measure overlaps with the target population of 0045, measure 2416 is restricted to fractures that require hospitalization whereas 0045 focuses on a broader population. Therefore we consider these measures to be related but not competing. The differences between this measure and 0045 are reflective of the different measure intents and level of accountability. In the attached memo on measure alignment, we have summarized where data elements in these two measures are aligned. 2417: Risk Assessment/Treatment after Fracture. Measure 2417 (currently under review for NQF endorsement) assesses the number of patients age 50+ who were hospitalized for a fragility fracture and have either a dual-energy x-ray absorptiometry (DXA) scan ordered or performed, a prescription for FDA-approved pharmacotherapy, or are linked to a fracture liaison service prior to discharge from an inpatient hospitalization. If DXA is not available and documented, then any other specified fracture risk assessment method may be ordered or performed. This measure has an overlapping target population (individuals hospitalized for a fragility fracture), but a different focus (screening and treatment provided in the hospital versus communication and care coordination). Therefore we consider these measures to be related but not competing. The differences between this measure and 0045 are reflective of the different measure intents and level of accountability. In the attached memo on measure alignment we have summarized where data elements in these two measures are aligned.

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.)

N/A

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](#) **Attachment:** 0045_Alignment_Memo.docx

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

Co.4 Point of Contact: Jill Marie, Farrell, farrell@ncqa.org, 202-955-1785-

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.

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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2003

Ad.3 Month and Year of most recent revision: 05, 2014

Ad.4 What is your frequency for review/update of this measure? Approximately every 3 years, sooner if clinical guidelines or evidence has changed significantly

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

Ad.6 Copyright statement: © 2003 by the National Committee for Quality Assurance
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Ad.7 Disclaimers: These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.
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