THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0

August 2008

The measure information you submit will be shared with NQF's Steering Committees and Technical Advisory Panels to evaluate measures against the NQF criteria of importance to measure and report, scientific acceptability of measure properties, usability, and feasibility. Four conditions (as indicated below) must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards. Not all acceptable measures will be strong—or equally strong—among each set of criteria. The assessment of each criterion is a matter of degree; however, all measures must be judged to have met the first criterion, importance to measure and report, in order to be evaluated against the remaining criteria. References to the specific measure evaluation criteria are provided in parentheses following the item numbers. Please refer to the *Measure Evaluation Criteria* for more information at *www.qualityforum.org* under Core Documents. Additional guidance is being developed and when available will be posted on the NQF website.

Use the tab or arrow (↓→) keys to move the cursor to the next field (or back ←↑). There are three types of response fields:

- drop-down menus - select one response;
- check boxes – check as many as apply; and
- text fields – you can copy and paste text into these fields or enter text; these fields are not limited in size, but in most cases, we ask that you summarize the requested information.

Please note that URL hyperlinks do not work in the form; you will need to type them into your web browser.

Be sure to answer all questions. Fields that are left blank will be interpreted as no or none. Information must be provided in this form. Attachments are not allowed except when specifically requested or to provide additional detail or source documents for information that is summarized in this form. If you have important information that is not addressed by the questions, they can be entered into item #48 near the end of the form.

For questions about this form, please contact the NQF Project Director listed in the corresponding call for measures.

	CONDITIONS FOR CONSIDERATION BY NQF
	Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards.
A (A)	**Public domain or Intellectual Property Agreement signed:** IP Agreement signed and submitted (If no, do not submit) *Template for the Intellectual Property Agreement is available at* **www.qualityforum.org** *under Core Documents.*
B (B)	**Measure steward/maintenance:** Is there an identified responsible entity and process to maintain and update the measure on a schedule commensurate with clinical innovation, but at least every 3 years? Yes, information provided in contact section (If no, do not submit)
C (C)	**Intended use:** Does the intended use of the measure include BOTH public reporting AND quality improvement? Yes (If no, do not submit)
D (D)	**Fully developed and tested:** Is the measure fully developed AND tested? Yes, fully developed and tested (If not tested and no plans for testing within 24 months, do not submit)

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MEASURE SUBMISSION FORM VERSION 3.0

August 2008

	(for NQF staff use) **NQF Review #:** EC-015-08 **NQF Project:** National Voluntary Consensus Standards for Ambulatory Care Using Clinically Enriched Administrative Data
	MEASURE SPECIFICATIONS & DESCRIPTIVE INFORMATION
1	**Information current as of** *(date- MM/DD/YY)*: 11/18/08
2	**Title of Measure:** Lead Screening in Children
3	**Brief description of measure [1]:** The percentage of children 2 years of age who received one or more capillary or venous blood test(s) for lead poisoning on or before their second birthday.
4 (2a)	**Numerator Statement:** At least one capillary or venous blood test on or before the child's second birthday. **Time Window:** the measurement year **Numerator Details** (Definitions, codes with description): Codes to identify Lead Tests: CPT: 83655 LOINC: 5671-3, 5674-7, 10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3
5 (2a)	**Denominator Statement:** Children who turn 2 years old during the measurement year. **Time Window:** Children continuously enrolled 12 months prior to the child's second birthday. **Denominator Details** (Definitions, codes with description):
6 (2a, 2d)	**Denominator Exclusions:** **Denominator Exclusion Details** (Definitions, codes with description):
7 (2a, 2h)	**Stratification** Do the measure specifications require the results to be stratified? Other ► If "other" describe: Measure is stratified by product line where the information is available (Medicaid). **Identification of stratification variable(s):** **Stratification Details** (Definitions, codes with description):
8 (2a, 2e)	**Risk Adjustment** Does the measure require risk adjustment to account for differences in patient severity before the onset of care? No ► **If yes,** (select one) ► Is there a separate proprietary owner of the risk model? No **Identify Risk Adjustment Variables:** **Detailed risk model:** attached ☐ **OR** Web page URL:
9 (2a)	**Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☐ **OR** Web page URL: **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 ► If "Other", please describe:

[1] Example of measure description: Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year.

10 (2a. 4a, 4b)

Identify the required data elements(e.g., primary diagnosis, lab values, vital signs)**:**
Data dictionary/code table attached ☐ **OR** Web page URL:
Data Quality (2a) *Check all that apply*
☒ Data are captured from an authoritative/accurate source (e.g., lab values from laboratory personnel)
☒ Data are coded using recognized data standards
☒ Method of capturing data electronically fits the workflow of the authoritative source
☒ Data are available in EHRs
☒ Data are auditable

11 (2a, 4b)

Data Source and Data Collection Methods *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply*

☒ Electronic Health/Medical Record
☐ Electronic Clinical Database, Name:
☐ Electronic Clinical Registry, Name:
☒ Electronic Claims
☐ Electronic Pharmacy data
☒ Electronic Lab data
☐ Electronic source – other, Describe:
☒ Paper Medical Record
☐ Standardized clinical instrument, Name:
☐ Standardized patient survey, Name:
☐ Standardized clinician survey, Name:
☐ Other, Describe:

Instrument/survey attached ☐ **OR** Web page URL:

12 (2a)

Sampling *If measure is based on a sample, provide instructions and guidance on sample size.*
Minimum sample size:

Instructions:

13 (2a)

Type of Measure: Process ► If "Other", please describe:

► If part of a composite or paired with another measure, please identify composite or paired measure

14 (2a)

Unit of Measurement/Analysis (*Who or what is being measured*) *Check all that apply.*

☒ Can be measured at all levels
☐ Individual clinician (e.g., physician, nurse)
☐ Group of clinicians (e.g., facility department/unit, group practice)
☐ Facility (e.g., hospital, nursing home)
☐ Integrated delivery system
☐ Health plan
☐ Community/Population
☐ Other (*Please describe*):

15 (2a)

Applicable Care Settings *Check all that apply*

☐ Can be used in all healthcare settings
☒ Ambulatory Care (office/clinic)
☐ Behavioral Healthcare
☐ Community Healthcare
☐ Dialysis Facility
☐ Emergency Department
☐ EMS emergency medical services
☒ Health Plan
☐ Home Health
☐ Hospice
☐ Hospital
☐ Long term acute care hospital
☐ Nursing home/ Skilled Nursing Facility (SNF)
☐ Prescription Drug Plan
☐ Rehabilitation Facility
☐ Substance Use Treatment Program/Center
☐ Other (*Please describe*):

IMPORTANCE TO MEASURE AND REPORT

Note: This is a threshold criterion. If a measure is not judged to be sufficiently important to measure and report, it will not be evaluated against the remaining criteria.

16 **Addresses a Specific National Priority Partners Goal** *Enter the numbers of the specific goals related*

(1a)	*to this measure (see list of goals on last page)*: 2.1
17 (1a)	**If not related to NPP goal, identify high impact aspect of healthcare** (select one) **Summary of Evidence:** **Citations[2] for Evidence:**
18 (1b)	**Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.* **Summary of Evidence:** Over the past several years, the emphasis in lead poisoning prevention has shifted from symptomatic adults in industrial settings to asymptomatic children with smaller exposures. Children are more sensitive to lead than adults because they exhibit greater hand-to-mouth activity. In addition, the gut of a child absorbs lead more readily than that of an adult and the developing central nervous system is more susceptible than the mature one. (Needleman 2004) One of the most important differences between adults and children with regard to lead poisoning is reversibility of symptoms. In adults, peripheral nervous system effects may reverse when the exposure ceases, but in children the central nervous system effects do not seem to do so. (Bellinger 2004) In a randomized, placebo-controlled, double-blind study, chelation treatment was shown to lower BLLs in children 12–33 months of age with initial blood lead levels between 20 and 45 µg/dL, but the chelation treatment did not improve their scores on tests of cognition, behavior or neuropsychological function at a follow-up of 36 months. (Rogan 2001) Lead poisoning in childhood primarily affects the central nervous system, the kidneys and the blood-forming organs. (Committee on Measuring Lead 1993) Adverse effects in young children have been noted at levels as low as 10 µg/dL and include impairments in cognitive function and initiation of various behavioral disorders. (Committee on Measuring Lead 1993) Pocock et al, in a systematic review in 1994 of the effects of lead on children's IQ's, found that a doubling of body lead from 10µg/dL to 20µg/dL was associated with a mean IQ deficit of 1–2 points. (Pocock 1994) More recent studies have noted effects of lead on cognitive ability at levels even below the level of concern of 10 µg/dL. Very high levels of lead exposure may result in serious, long-term neurological sequelae or even death. Before chelation therapy, 28 percent–45 percent of lead-poisoned children who presented with signs or symptoms of encephalopathy died. (Lanphear 2003) With the advent of chelation therapy, and with imposed environmental changes and greater public awareness, death from lead poisoning has now become a rare event in the United States. In 2002, Lustberg and Silbergeld evaluated the association between lead exposure and mortality in the U.S. After adjusting for potential confounders (e.g., smoking, income, education), individuals with a BLL of 20 µg/dL–29 µg/dL had a 46 percent increased all-cause mortality compared with those with BLLs of <10 µg/dL. Individuals with BLLs between 10 µg/dL and 20 µg/dL showed no statistically significant increase in all-cause mortality. (Lustberg 2002). The NHANES reported that children 1–5 years of age have the highest prevalence of elevated blood levels of any age group in the U.S., and youths 6–19 years of age have the lowest. Adults >60 have the highest geometric mean (GM) BLLs, followed by children 1–5 years. In addition, males have significantly higher GM BLLs than females for all age groups except 1–5 years, where levels were the same (MMWR May 27, 2005). BLLs of black children and among low-income families remain significantly higher than those of other races and income status. The prevalence of high BLLs among children 1–5 years of age in the U.S. population has declined over the past several decades. From 1976–1980 to 1991–1994, the percentage of children 1–5 years with a BLL of >10 µg/dL decreased from 77.8 percent to 4.4 percent. The prevalence of increased BLLs in this same age group decreased further, to 1.6 percent, in the NHANES survey conducted during the 1999–2002 period. Even with these decreases, an estimated 310,000 children in this country remain at risk for exposure to harmful levels of lead. (MMWR May 27, 2005) Much of the reduction in BLLs is thought to have occurred because of the removal of lead from gasoline, paint and food cans (President's Task Force 2000). In young, asymptomatic children, BLLs as low as 10 micro-g/dL are associated with measurable neurodevelopment dysfunction. Although the national prevalence of elevated lead levels has declined substantially in the past decade, a high prevalence persists in some communities, particularly in poor

[2] Citations can include, but are not limited to journal articles, reports, web pages (URLs).

urban communities in the northeastern U.S. Measurement of venous blood lead concentration is a convenient, reliable, precise and reasonably valid screening test for assessing lead exposure (USPSTF 1996).

The MMWR report also noted that the prevalence of increased BLLs was higher among non-Hispanic black children than White/Non-Hispanic children and Mexican American children. There was insufficient statistical power to examine the differences because of insufficient data size and variability around the estimates, but the geometric mean BLL was significantly higher for non-Hispanic blacks (2.8 µg/dL) than for Mexican Americans (1.9 µg/dL) and non-Hispanic whites (1.8 µg/dL). There was a significant decline in the GM BLL in children 1–5 years of age from families with low income between the 1991–1994 and 1999–2002 surveys (3.7 µg/dL–2.5 µg/dL). (MMWR May 27, 2005) Children at high risk also include those participating in federal health care programs such as Medicaid and WIC. 77 percent of all the children 1–5 years of age with an elevated BLL in a 1991–1994 CDC survey were participating in federal health care programs. This amounted to almost 700,000 children across the nation. In addition, over 8 percent of the children who were served by federal health care programs had a harmful BLL. This amounted to a rate almost five times that for children who were not in these federal programs. Despite the recommendation by the CDC to screen all children in the federal health care programs, only about 18 percent of Medicaid children had been screened at that time (General Accounting Office 1999).

Factors associated with increased exposure to lead include dust and soil contamination from lead-based industry; hobbies or occupations that expose one to lead; and decrepit housing with lead-based paint. Increased exposure can also come from dietary intake, such as eating food from lead-soldered cans or lead-based pottery, or drinking water from lead-soldered pipes. (American Academy of Pediatrics 2005)

There are two commonly accepted methods of screening children for lead poisoning: venous blood sampling and capillary blood sampling. The venous method is the most accurate way to measure lead in blood, but capillary screening is the easiest way to screen young children since it does not require a venous blood draw. Capillary testing appears to be less accurate and more prone to contamination of the sample than venous blood lead, with false-positive rates of 3 percent–9 percent, and false-negative rates of 1 percent–8 percent. (USPSTF 1996) A review of research indicates that risk questionnaires are not very reliable to use as a method of screening children for lead poisoning. In 1991, the CDC recommended the use of a questionnaire to screen children for risk of lead exposure—not as a replacement for blood lead screening but as a way of determining the appropriate frequency of testing children for lead poisoning. Several studies subsequently determined that the test demonstrated a sensitivity of 64 percent–87 percent, a specificity of 32 percent–75 percent and a positive predictive value between 3.6 percent and 35 percent. (France 1996)

Citations for Evidence:

American Academy of Pediatrics. Policy Statement. Lead Exposure in Children: Prevention, Detection, and Management. Pediatrics. Vol. 116 No. 4 October 2005, pp. 1036-1046 Accessed Oct 13, 2005 online at: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;116/4/1036.pdf.
Bellinger, D.C. Lead. Pediatrics. 2004 Apr;113(4 Suppl):1016-22.
Centers for Disease Control and Prevention. Blood Lead Levels—United States, 1999–2002. MMWR Morbidity & Mortality Weekly Report. May 2005;54(20):513-516.
Committee on Measuring Lead in Critical Populations NRC. Measuring lead exposure in infants, children, and other sensitive populations. Washington DC: National Academy Press. 1993. Accessed Oct 10, 2005, at: http://www.nap.edu/books/030904927X/html/R1.html.
France, E.K., B.A. Gitterman, P. Melinkovich, R.A. Wright. The accuracy of a lead questionnaire in predicting elevated pediatric blood lead levels. Arch Pediatr Adolesc Med. 1996 Sep;150(9):958-63.
General Accounting Office. Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children. Washington, DC: General Accounting Office; 1999. Publication GAO-HEHE-99-18.
Lanphear, B.P., K.N. Dietrich, O. Berger. Prevention of lead toxicity in US children. Ambulatory Pediatrics. 2003;3(1):27-36. Accessed online Oct 10, 2005, at http://www.nap.edu/books/030904927X/html/R1.html.
Lustberg, M., E. Silbergeld. Blood lead levels and mortality. Arch Intern Med. 2002 Nov 25;162(21):2443-9.
Needleman, H.L. Lead poisoning. Annual Review of Medicine. 2004;55:209-222
Pocock, S.J., M. Smith, P. Baghurst. Environmental lead and children's intelligence: a systematic review of the epidemiological evidence. BMJ. 1994 Nov 5;309(6963):1189-97.
President's Task Force on Environmental Health Risks and Safety Risks to Children, US Department of

	Housing and Urban Development. Eliminating childhood lead poisoning: a federal strategy targeting lead paint hazards. 2000. Washington, DC: US Department of Housing and Urban Development; 2000. Accessed October 14, 2005, at http://www.hud.gov/offices/lead/reports/fedstrategy2000.pdf. Rogan, W.J., K.N. Dietrich, et al. The effect of chelation therapy with succimer on neuropsychological development in children exposed to lead. N Engl J Med. 2001 May 10;344(19):1421-6. United States Preventive Services Task Force. 1996. Chapter 23, Screening for Elevated Lead Levels in Childhood and Pregnancy. Guide to Clinical Preventive Services: Second Edition. 1996. Accessed October 17, 2005, at: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat3.part.19920.
19 (1b)	**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.* **Summary of Evidence:** The prevalence of high BLLs among children 1–5 years of age in the U.S. population has declined over the past several decades. From 1976–1980 to 1991–1994, the percentage of children 1–5 years with a BLL of >10 µg/dL decreased from 77.8 percent to 4.4 percent. The prevalence of increased BLLs in this same age group decreased further, to 1.6 percent, in the NHANES survey conducted during the 1999–2002 period. BLLs of black children and among low-income families remain significantly higher than those of other races and income status. Even with decreases in BLLs, an estimated 310,000 children in this country remain at risk for exposure to harmful levels of lead. (MMWR May 27, 2005) Much of the reduction in BLLs is thought to have occurred because of the removal of lead from gasoline, paint and food cans (President's Task Force 2000). In young, asymptomatic children, BLLs as low as 10 micro-g/dL are associated with measurable neurodevelopment dysfunction. Although the national prevalence of elevated lead levels has declined substantially in the past decade, a high prevalence persists in some communities, particularly in poor urban communities in the northeastern U.S. Measurement of venous blood lead concentration is a convenient, reliable, precise and reasonably valid screening test for assessing lead exposure (USPSTF 1996). The MMWR report also noted that the prevalence of increased BLLs was higher among non-Hispanic black children than White/Non-Hispanic children and Mexican American children. There was insufficient statistical power to examine the differences because of insufficient data size and variability around the estimates, but the geometric mean BLL was significantly higher for non-Hispanic blacks (2.8 µg/dL) than for Mexican Americans (1.9 µg/dL) and non-Hispanic whites (1.8 µg/dL). There was a significant decline in the GM BLL in children 1–5 years of age from families with low income between the 1991–1994 and 1999–2002 surveys (3.7 µg/dL–2.5 µg/dL). (MMWR May 27, 2005) Children at high risk also include those participating in federal health care programs such as Medicaid and WIC. 77 percent of all the children 1–5 years of age with an elevated BLL in a 1991–1994 CDC survey were participating in federal health care programs. This amounted to almost 700,000 children across the nation. In addition, over 8 percent of the children who were served by federal health care programs had a harmful BLL. This amounted to a rate almost five times that for children who were not in these federal programs. Despite the recommendation by the CDC to screen all children in the federal health care programs, only about 18 percent of Medicaid children had been screened at that time (General Accounting Office 1999). Factors associated with increased exposure to lead include dust and soil contamination from lead-based industry; hobbies or occupations that expose one to lead; and decrepit housing with lead-based paint. Increased exposure can also come from dietary intake, such as eating food from lead-soldered cans or lead-based pottery, or drinking water from lead-soldered pipes. (American Academy of Pediatrics 2005) **Citations for evidence:** American Academy of Pediatrics. Policy Statement. Lead Exposure in Children: Prevention, Detection, and Management. Pediatrics. Vol. 116 No. 4 October 2005, pp. 1036-1046 Accessed Oct 13, 2005 online at: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;116/4/1036.pdf. Centers for Disease Control and Prevention. Blood Lead Levels—United States, 1999–2002. MMWR Morbidity & Mortality Weekly Report. May 2005;54(20):513-516. General Accounting Office. Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children. Washington, DC: General Accounting Office; 1999. Publication GAO-HEHE-99-18.

	President's Task Force on Environmental Health Risks and Safety Risks to Children, US Department of Housing and Urban Development. Eliminating childhood lead poisoning: a federal strategy targeting lead paint hazards. 2000. Washington, DC: US Department of Housing and Urban Development; 2000. Accessed October 14, 2005, at http://www.hud.gov/offices/lead/reports/fedstrategy2000.pdf. United States Preventive Services Task Force. 1996. Chapter 23, Screening for Elevated Lead Levels in Childhood and Pregnancy. Guide to Clinical Preventive Services: Second Edition. 1996. Accessed October 17, 2005, at: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat3.part.19920.
20 (1c)	**If measuring an Outcome** Describe relevance to the national health goal/priority, condition, population, and/or care being addressed: **If not measuring an outcome, provide evidence supporting this measure topic and grade the strength of the evidence** *Summarize the evidence (including citations to source) supporting the focus of the measure as follows:* • Intermediate outcome – evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit. • Process – evidence that the measured clinical or administrative process leads to improved health/avoidance of harm and if the measure focus is on one step in a multi-step care process, it measures the step that has the greatest effect on improving the specified desired outcome(s). • Structure – evidence that the measured structure supports the consistent delivery of effective processes or access that lead to improved health/avoidance of harm or cost/benefit. • Patient experience – evidence that an association exists between the measure of patient experience of health care and the outcomes, values and preferences of individuals/ the public. • Access – evidence that an association exists between access to a health service and the outcomes of, or experience with, care. • Efficiency– demonstration of an association between the measured resource use and level of performance with respect to one or more of the other five IOM aims of quality. **Type of Evidence** *Check all that apply* ☒ Evidence-based guideline ☐ Quantitative research studies ☐ Meta-analysis ☐ Qualitative research studies ☒ Systematic synthesis of research ☐ Other (*Please describe*): **Overall Grade for Strength of the Evidence**[3] (*Use the USPSTF system, or if different, also describe how it relates to the USPSTF system)*: **Summary of Evidence** (*provide guideline information below*)**:** **Citations for Evidence:**
21 (1c)	**Clinical Practice Guideline** *Cite the guideline reference; quote the specific guideline recommendation related to the measure and the guideline author's assessment of the strength of the evidence; and summarize the rationale for using this guideline over others.* **Guideline Citation:** American Academy of Pediatrics. Policy Statement. Lead Exposure in Children: Prevention, Detection, and Management. Pediatrics. Vol. 116 No. 4 October 2005, pp. 1036-1046 Accessed Oct 13, 2005 online at: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;116/4/1036.pdf.

[3]The strength of the body of evidence for the specific measure focus should be systematically assessed and rated, e.g., USPSTF grading system www.ahrq.gov/clinic/uspstmeth.htm: A - The USPSTF recommends the service. There is high certainty that the net benefit is substantial. B - The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. C - The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. Offer or provide this service only if other considerations support the offering or providing the service in an individual patient. D - The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. I - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

CDC. Preventing lead poisoning in young children. Atlanta (GA): CDC; 2005 Aug. 101 p. [139 references].
CDC. Screening young children for lead poisoning: guidance for state and local health officials. Atlanta, GA: USDHHS, CDC, National Center for Environmental Health, 1997. Accessed Oct 10, 2005, at: http://www.cdc.gov/nceh/lead/guide/guide97.htm.
Lane, W.G., A.R. Kemper. American College of Preventive Medicine Practice Policy Statement. Screening for elevated blood lead levels in children. Am J Prev Med. 2001 Jan; 20 (1): 78-82. [40 references]
Rischitelli, G., P. Nygren, et al. Screening for elevated lead levels in childhood and pregnancy: an updated summary of evidence for the US Preventative Services Task Force. Pediatrics. 2006; 118; 1867-1895. Accessed on December 7, 2006, at: http://www.pediatrics.org/cgi/content/full/118/6/e1867.

Specific guideline recommendation:
In 1997, the CDC updated its lead screening recommendations due to the falling prevalence of elevated BLLs. Rather than performing universal screening, the CDC recommends universal screening among children receiving Medicaid or WIC. The CDC also recommends that state health officials develop a statewide lead screening program, with targeted screening recommendations for particular areas of the state (CDC 1997). In addition, the CDC recommends that health care providers continue their traditional role of providing anticipatory guidance as part of routine well-child care, assessing risk for exposure to lead, conducting blood lead screening in children and treating children identified with elevated BLLs. The CDC recommends that health care and social service providers should become aware of and comply with lead screening policies issued by Medicaid or state and local health departments. (CDC 2005)

The American Academy of Pediatrics guidelines recommend to pediatricians,
"Know state Medicaid regulations and measure blood lead concentration in Medicaid-eligible children." In addition, the guidelines state, "Find out if there is relevant guidance from the city or state health department about screening children not eligible for Medicaid. If there is none, consider screening all children. Children should be tested at least once when they are 2 years of age or, ideally, twice, at 1 and 2 years of age, unless lead exposure can be confidently excluded." (AAP 2005)
Medicaid guidelines state, "Current CMS policy requires a screening blood lead test for all Medicaid-eligible children at 12- and 24-months of age. In addition, children over the age of 24 months, up to 72 months of age, should receive a screening blood lead test if there is no record of a previous test." (Centers for Medicare and Medicaid Services)

In 2006, the USPSTF gave a recommendation of, I–Insufficient evidence to recommend for or against lead screening in children due to the lack of evidence linking screening with improved outcomes. The USPSTF reviewed the evidence for screening children, not particular subgroups such as children enrolled in Medicaid. With regard to targeted screening; the USPSTF did not find direct evidence (from controlled studies) comparing the outcomes of universal screening with the outcomes from targeted screening. It summarized that, although the prevalence of elevated BLLs had declined overall, local prevalence is highly variable, with a >10-fold difference between communities. Mean BLLs among black children remain significantly higher than Mexican American children and non-Hispanic white children. The USPSTF encourages clinicians to consult their local or state health departments regarding appropriate screening policies for their populations. Targeted screening and intervention may be best directed and effective for children who have the following risk factors, such as younger than 5 years of age, urban residence, low income, low parental education, pre-1950 housing and recent immigration. In addition children may have increased risk from lead-based hobbies or industries, ethnic remedies or lead-based pottery. (Rischitelli 2006)

The American College of Preventive Medicine (ACPM) recommends that screening for elevated lead levels via venous or capillary blood lead testing should be conducted for children 1 year of age only if they are identified as being at high risk for elevated BLLs. Identification of high-risk children include those who receive Medicaid or WIC, live in a community with ≥12 percent prevalence of BLLs at 10 µg/dL or more, live in a community with ≥27% of homes built before 1950 or meet one or more high-risk criteria of a lead-screening questionnaire. Follow-up services for children with BLLs between 10 µg/dL–19 µg/dL include obtaining confirmatory venous BLL within a month, providing education on decreasing blood lead exposure and repeating a BLL test within 2–3 months. (Lane 2001)

Guideline author's rating of strength of evidence (*If different from USPSTF, also describe it and how it relates to USPSTF)*: The guidelines align with the USPSTF grading system and were developed by national

	agencies. **Rationale for using this guideline over others:** The guidelines included are evidence-based, applicable to relevant providers, and developed by national specialty organizations or government agencies.
22 (1c)	**Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.* **Summary:** **Citations:**
23 (1)	**Briefly describe how this measure (as specified) will facilitate significant gains in healthcare quality related to the specific priority goals and quality problems identified above:** The CDC and Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program highlight the importance of lead screening in children. A HEDIS lead screening measure would be a powerful tool that Medicaid programs could use to hold health plans and providers accountable for improving lead screening rates. Additionally, a standardized national lead screening measure would allow the CDC and others to track and trend performance at varying levels of the health care system (e.g., plan-to-plan and state-to-state comparison, development of national statistics and benchmarks) Lead toxicity screening is one of several screening services required by the EPSDT program.
	SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES
	Note: Testing and results should be summarized in this form. However, additional detail and reports may be submitted as supplemental information or provided as a web page URL. If a measure has not been tested, it is only potentially eligible for time-limited endorsement.
24	**Supplemental Testing Information:** attached ☐ **OR** Web page URL:
25 (2b)	**Reliability Testing** **Data/sample:** **Analytic Method:** **Testing Results:**
26 (2c)	**Validity Testing** **Data/sample:** **Analytic Method:** **Testing Results:**
27 (2d)	**Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.* **Summary of Evidence supporting exclusion(s):** **Citations for Evidence:** **Data/sample:** **Analytic Method:** **Testing Results:**
28 (2e)	**Risk Adjustment Testing** *Summarize the testing used to determine the need (or no need) for risk adjustment and the statistical performance of the risk adjustment method.* **Data/sample:**

	Analytic Method: **Testing Results:** ►**If outcome or resource use measure not risk adjusted, provide rationale:**
29 (2g)	**Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*) **Data/sample:** Six plans participated in the 2007 field test for the lead screening in children measure. Three of the six plans provided the full administrative-only results while the five of the six plans provided the hybrid results which was a combination of administrative and medical record numerator hits for a sample of 150 children from the eligible population. **Analytic Method:** For purposes of the field test, the measurement year was 2005. The participating plans were asked to provide patient, lead test, and plan data from administrative data systems for the entire eligible population, and a subset of information from medical records. The reason for including certain information from both administrative sources and medical records was to verify the completeness and accuracy from each of the sources of data. The sampling strategy was designed to illustrate rate variation. **Results:** Of the combined samples of the eligible population from 6 plans, of the 61% of children who had lead screening tests performed, 85% of those screenings would have been found if looking only at administrative data. In comparison, of the 61% of children who had lead screening test performed, 49% of those screenings would have been found if looking only at medical record data. As a stand alone method, the administrative method is preferable to medical record only. Though given there were about 9% of tests found in the medical record data that were not in the administrative data, the hybrid method is preferable to either alone. To limit additional burden, the medical record sample is proposed as the same sample as from the Childhood Immunization Status (CIS) HEDIS measure Health plans have the ability to identify the target population, children with Medicaid coverage, and use educational interventions to stress the importance of lead screening. As seen in the NCQA field-test, there is variation between plans and quite a bit of room for improvement. Screening rates for one capillary or venous blood test falling on or before the child's second birthday, ranged from 39 percent- 85 percent using the hybrid method. The measure is specified to address the age group and product line that is both most at risk for elevated BLLs and receives the most benefit for lead screening. Per federal policy, if elevated lead levels are found, Medicaid coverage is available for all necessary case management services, as well as for environmental investigation to determine the source of the child's lead exposure.
30 (2f)	**Provide Measure Results from Testing or Current Use** Results from current use **Data/sample:** This measure is reported by Medicaid plans on all children 2 years of age. **Methods to identify statistically significant and practically/meaningfully differences in performance:** **Results:** Publicly reported for the first time in 2008, average Medicaid plan performance was 61.4 percent, performance in the 10th percentile was 32.3 percent and the 90th percentile was 84.0 percent.
31 (2h)	**Identification of Disparities** ►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:** ►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale:
	USABILITY
32 (3)	**Current Use** In use **If in use, how widely used** Nationally ► If "other," please describe: ☒ Used in a public reporting initiative, name of initiative: NCQA's State of Health Care Quality Report.

	Sample report attached ☐ **OR** Web page URL: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf
33 (3a)	**Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **Data/sample:** **Methods:** **Results:**
34 (3b, 3c)	**Relation to other NQF-endorsed™ measures** ►Is this measure similar or related to measure(s) already endorsed by NQF (on the same topic or the same target population)? *Measures can be found at www.qualityforum.org under Core Documents.* *Check all that apply* ☒ Have not looked at other NQF measures ☐ Other measure(s) on same topic ☐ Other measure(s) for same target population ☐ No similar or related measures **Name of similar or related NQF-endorsed™ measure(s):** **Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one) ►If not fully harmonized, provide rationale: **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:**
	FEASIBILITY
35 (4a)	**How are the required data elements generated?** *Check all that apply* ☐ Data elements are generated concurrent with and as a byproduct of care processes during care delivery (e.g., blood pressure or other assessment recorded by personnel conducting the assessment) ☐ Data elements are generated from a patient survey (e.g., CAHPS) ☒ Data elements are generated through coding performed by someone other than the person who obtained the original information (e.g., DRG or ICD-9 coding on claims) ☐ Other, Please describe:
36 (4b)	**Electronic Sources** All data elements ►**If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:** ►**Specify the data elements for the electronic health record:**
37 (4c)	**Do the specified exclusions require additional data sources beyond what is required for the other specifications?** No ►**If yes, provide justification:**
38 (4d)	**Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure:** **Describe how could these potential problems be audited:** **Did you audit for these potential problems during testing?** (select one) **If yes, provide results:**
39 (4e)	**Testing feasibility** Describe what have you learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:

	CONTACT INFORMATION
40	**Web Page URL for Measure Information** *Describe where users (implementers) should go for more details on specifications of measures, or assistance in implementing the measure.* **Web page URL:** www.ncqa.org/pcs
41	**Measure Intellectual Property Agreement Owner Point of Contact** **First Name:** Philip **MI:** **Last Name:** Renner **Credentials (MD, MPH, etc.):** MBA **Organization:** National Committee For Quality Assurance **Street Address:** 1100 13th Street NW, Suite 1000 **City:** Washington **State:** DC **ZIP:** 20005 **Email:** renner@ncqa.org **Telephone:** 202-955-5192 ext:
42	**Measure Submission Point of Contact** **If different than IP Owner Contact** **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:** **Email:** **Telephone:** ext:
43	**Measure Developer Point of Contact** **If different than IP Owner Contact** **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:** **Email:** **Telephone:** ext:
44	**Measure Steward Point of Contact** **If different than IP Owner Contact** *Identifies the organization that will take responsibility for updating the measure and assuring it is consistent with the scientific evidence and current coding schema; the steward of the measure may be different than the developer.* **First Name:** **MI:** **Last Name:** **Credentials (MD, MPH, etc.):** **Organization:** **Street Address:** **City:** **State:** **ZIP:** **Email:** **Telephone:** ext
	ADDITIONAL INFORMATION
45	**Workgroup/Expert Panel involved in measure development** Workgroup/panel used ►If workgroup used, describe the members' role in measure development: This panel supported the development of the lead screening measure to ensure that it aligns with clinical guideslines and practices and was feasible for health plan collection and reporting. ►Provide a list of workgroup/panel members' names and organizations: Lead Screening Expert Panel convened - Dr. Mary Jean Brown - Carlos Hernandez - Barbara Hurley - Dr. Rita Mangione-Smith - Dr. Walter Rogan - Patrick Roohan - Linda Rudolph - Dr. Michael Shannon - Paula Staley - Anne Wengrovitz
46	**Measure Developer/Steward Updates and Ongoing Maintenance** Year the measure was first released: 2008 Month and Year of most recent revision: 2007 What is the frequency for review/update of this measure? This measure went through first year analysis in 2007. Now that it is a publicly reported measure it will be reviewed approximately every three years through NCQA's re-evaluation process. The measure specifications are reviewed annually to make sure the specifications language and coding are up to date. When is the next scheduled review/update for this measure? 11/18/08

47	**Copyright statement/disclaimers:** These performance measures were developed and are owned by the National Committee for Quality Assurance ("NCQA"). These performance measures are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures. NCQA holds a copyright in these measures and can rescind or alter these measures at any time. Users of the measures shall not have the right to alter, enhance, or otherwise modify the measures and shall not disassemble, recompile, or reverse engineer the source code or object code relating to the measures. Anyone desiring to use or reproduce the measures without modification for a noncommercial purpose may do so without obtaining any approval from NCQA. All commercial uses must be approved by NCQA and are subject to a license at the discretion of NCQA. ©2007 National Committee for Quality Assurance, all rights reserved. Note: Performance measures developed by NCQA for CMS may look different from the measures solely created and owned by NCQA for NCQA.
48	**Additional Information:**
49	**I have checked that the submission is complete and any blank fields indicate that no information is provided.** ☒
50	**Date of Submission** (*MM/DD/YY*)**:**

PATIENT & FAMILY ENGAGEMENT

PRIORITY STATEMENT: Engage Patients and Their Families in Managing Their Health and Making Decisions About Their Care

1.1. All providers will routinely solicit and publicly report on their patients' perspectives of care

1.2. All providers will work collaboratively with their patients to assist them in making informed decisions about treatment options consistent with their values and preferences

POPULATION HEALTH

PRIORITY STATEMENT: IMPROVE THE HEALTH OF THE U.S. POPULATION

2.1. The population will be up to date on all high-priority age- and gender-appropriate evidence-based clinical preventive services

2.2. The population will receive recommended evidence-based interventions to improve targeted healthy lifestyle behaviors

2.3. All communities will demonstrate a 10% improvement in their community index of health

2.4. Americans will have all recommended high priority healthy lifestyle behaviors under control

SAFETY

PRIORITY STATEMENT: IMPROVE THE SAFETY OF THE U.S. HEALTH CARE SYSTEM

3.1. All providers will drive all preventable healthcare-associated infections (HAI) to zero

3.2. All providers will drive the incidence of preventable NQF Serious Reportable Events (SRE) to zero

3.3. All hospitals will reduce preventable and premature mortality rates to best-in-class

3.4. All hospitals and their community partners will reduce 30-day mortality rates following hospitalization for select conditions to best-in-class

PALLIATIVE CARE

PRIORITY STATEMENT: GUARANTEE APPROPRIATE AND COMPASSIONATE CARE FOR PATIENTS WITH LIFE-LIMITING ILLNESSES

4.1. All providers will identify, document, and effectively treat physical symptoms (e.g. pain, shortness of breath, constipation, others) at levels acceptable to patients with a life-limiting illness

4.2. All providers will effectively address the psychosocial and spiritual needs of patients with life-limiting illnesses and their families according to their preferences

4.3. All eligible patients will receive high quality palliative care and hospice services

CARE COORDINATION

PRIORITY STATEMENT: ENSURE PATIENTS RECEIVE WELL-COORDINATED CARE ACROSS ALL PROVIDERS, SETTINGS, AND LEVELS OF CARE

5.1. All providers will accurately and completely reconcile medications across the continuum of care (i.e. admission, transfer within and between care providers, discharge, and outpatient appointments) and ensure communication with the next provider of services

5.2. All inpatient and outpatient providers will assess the patient's perspective of the coordination of their care using a validated care coordination survey tool

5.3. All providers will reduce 30-day all-cause readmission rates resulting from poorly coordinated care to best-in-class

5.4. All providers will reduce preventable emergency department (i.e. those that could be avoided with timely access to primary care) visits resulting from poorly coordinated care by 50%

PATIENT-FOCUSED CARE

PRIORITY STATEMENT: GUARANTEE HIGH VALUE CARE ACROSS ACUTE AND CHRONIC EPISODES

6.1. All patients will receive high-value care over the course of their acute or chronic illness

OVERUSE

PRIORITY STATEMENT: ELIMINATE WASTE WHILE ENSURING THE DELIVERY OF APPROPRIATE CARE

7.1. Reduce wasteful and inappropriate care for the top ten targeted areas by 50%

THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0
August 2008

The measure information you submit will be shared with NQF's Steering Committees and Technical Advisory Panels to evaluate measures against the NQF criteria of importance to measure and report, scientific acceptability of measure properties, usability, and feasibility. Four conditions (as indicated below) must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards. Not all acceptable measures will be strong—or equally strong—among each set of criteria. The assessment of each criterion is a matter of degree; however, all measures must be judged to have met the first criterion, importance to measure and report, in order to be evaluated against the remaining criteria. References to the specific measure evaluation criteria are provided in parentheses following the item numbers. Please refer to the *Measure Evaluation Criteria* for more information at *www.qualityforum.org* under Core Documents. Additional guidance is being developed and when available will be posted on the NQF website.

Use the tab or arrow (↓→) keys to move the cursor to the next field (or back ←↑). There are three types of response fields:

- drop-down menus - select one response;
- check boxes – check as many as apply; and
- text fields – you can copy and paste text into these fields or enter text; these fields are not limited in size, but in most cases, we ask that you summarize the requested information.

Please note that URL hyperlinks do not work in the form; you will need to type them into your web browser.

Be sure to answer all questions. Fields that are left blank will be interpreted as no or none. Information must be provided in this form. Attachments are not allowed except when specifically requested or to provide additional detail or source documents for information that is summarized in this form. If you have important information that is not addressed by the questions, they can be entered into item #48 near the end of the form.

For questions about this form, please contact the NQF Project Director listed in the corresponding call for measures.

	CONDITIONS FOR CONSIDERATION BY NQF
	Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards.
A (A)	**Public domain or Intellectual Property Agreement signed:** IP Agreement signed and submitted (If no, do not submit) *Template for the Intellectual Property Agreement is available at* **www.qualityforum.org** *under Core Documents.*
B (B)	**Measure steward/maintenance:** Is there an identified responsible entity and process to maintain and update the measure on a schedule commensurate with clinical innovation, but at least every 3 years? Yes, information provided in contact section (If no, do not submit)
C (C)	**Intended use:** Does the intended use of the measure include BOTH public reporting AND quality improvement? Yes (If no, do not submit)
D (D)	**Fully developed and tested:** Is the measure fully developed AND tested? Yes, fully developed and tested (If not tested and no plans for testing within 24 months, do not submit)

THE NATIONAL QUALITY FORUM

MEASURE SUBMISSION FORM VERSION 3.0

August 2008

	(for NQF staff use) **NQF Review #:** EC-053-08 **NQF Project:** National Voluntary Consensus Standards for Ambulatory Care Using Clinically Enriched Administrative Data
	MEASURE SPECIFICATIONS & DESCRIPTIVE INFORMATION
1	**Information current as of** *(date- MM/DD/YY)*: 10/31/08
2	**Title of Measure:** Tympanostomy Tube Hearing Test
3	**Brief description of measure** [1]**:** This measure identifies the percentage of patients age 2 through 12 years with OME who received tympanostomy tube(s) insertion during the measurement year and had a hearing test performed within 6 months prior to the initial tube placement.
4 (2a)	**Numerator Statement:** Patients from the denominator who underwent hearing testing within 6 months prior to the initial tympanostomy tube(s) insertion **Time Window:** See below **Numerator Details** (Definitions, codes with description): - >=1 claim with a procedure code for 'Hearing Test' (see below for applicable procedure codes) in the 6 months prior to the 'index tube insertion date' (see denominator details below) Hearing Test (Procedure) Type Code Description CPT4 92506 SPEECH/HEARING EVALUATION CPT4 92551 SCREENING TEST PURE TONE AIR ONLY CPT4 92552 PURE TONE AUDIOMETRY; AIR ONLY CPT4 92553 PURE TONE AUDIOMETRY; AIR AND BONE CPT4 92555 SPEECH AUDIOMETRY THRESHOLD; CPT4 92556 SPEECH AUDIOM THRESHLD; W/RECOGNITN CPT4 92557 COMP AUDIOMETRY THRESHOLD EVAL CPT4 92561 BEKESY AUDIOMETRY; DIAGNOSTIC CPT4 92562 LOUD BALANC TEST ALTERN BI/MONAURAL CPT4 92563 TONE DECAY TEST CPT4 92564 SHORT INCREMENT SENSITIVITY INDEX CPT4 92567 TYMPANOMETRY CPT4 92568 ACOUSTIC REFL THRESHOLD TST CPT4 92569 ACOUSTIC REFLEX DECAY TEST CPT4 92571 FILTERED SPEECH TEST CPT4 92572 STAGGERED SPONDAIC WORD TEST CPT4 92575 SENSORINEURAL ACUITY LEVEL TEST CPT4 92576 SYNTHETIC SENTENCE ID TEST CPT4 92577 STENGER TEST SPEECH CPT4 92579 VISUAL REINFORCEMENT AUDIOMETRY CPT4 92582 CONDITIONING PLAY AUDIOMETRY CPT4 92583 SELECT PICTURE AUDIOMETRY CPT4 92585 AUD EVOKD POTNT &/ TEST CNS; COMP CPT4 92586 AUD EVOKD POTENT &/ TEST CNS; LTD CPT4 92587 EVOKED OTOACOUSTIC EMISSIONS; LTD

[1] Example of measure description: Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year.

	HSREV 0471 Audiology ICD9P 9541 AUDIOMETRY ICD9P 9542 CLINICAL TEST OF HEARING ICD9P 9543 AUDIOLOGICAL EVALUATION ICD9P 9547 HEARING EXAMINATION NOS
5 (2a)	**Denominator Statement:** Patients age 2 through 12 years old with OME who received tympanostomy tube(s) insertion during the measurement year **Time Window:** See below **Denominator Details** (Definitions, codes with description): - Age >=2 years as of start of measurement year AND <=12 years as of the end of the measurement year - AND >=1 claim with a diagnosis code for 'Otitis Media with Effusion' (see below for applicable diagnosis codes) from an office visit 'Otitis Visit' during the measurement year - AND >=1 claim with a procedure code for 'Tympanostomy Tube Insertion' (see below for applicable procedure codes) during the measurement year, in which the earliest claim date is considered the 'index tube insertion date' - AND no claims with a procedure code for 'Tympanostomy Tube Insertion' in the 6 months prior to the 'index tube insertion date' - AND member eligibility for medical services during the 6 month period prior to the 'index tube insertion date' Otitis Media with Effusion (Diagnosis) Type Code Description ICD9 38110 SMPL/UNS CHRON SEROUS OTITIS MEDIA ICD9 38119 OTHER CHRONIC SEROUS OTITIS MEDIA ICD9 38120 SMPL/UNS CHRON MUCOID OTITIS MEDIA ICD9 38129 OTHER CHRONIC MUCOID OTITIS MEDIA ICD9 3813 OTH&UNS CHRN NONSUPPRATV OTIT MEDIA ICD9 3814 NONSUPPRATV OTIT MEDIA NOT AC/CHRN Otitis Visit (Procedure) Type Code Description CPT4 99201 OFFICE/OUTPATIENT VISIT, NEW CPT4 99202 OFFICE/OUTPATIENT VISIT, NEW CPT4 99203 OFFICE/OUTPATIENT VISIT, NEW CPT4 99204 OFFICE/OUTPATIENT VISIT, NEW CPT4 99205 OFFICE/OUTPATIENT VISIT, NEW CPT4 99212 OFC/OUTPT E&M ESTAB MINOR 10 MIN CPT4 99213 OFC/OUTPT E&M ESTAB LOW-MOD 15 MIN CPT4 99214 OFC/OUTPT E&M ESTAB MOD-HI 25 MIN CPT4 99215 OFC/OUTPT E&M ESTAB MOD-HI 40 MIN CPT4 99241 OFFICE CNSLT NEW/ESTAB MINOR 15 MIN CPT4 99242 OFC CNSLT NEW/EST LOW SEVER 30 MIN CPT4 99243 OFFICE CNSLT NEW/ESTAB MOD 40 MIN CPT4 99244 OFC CNSLT NEW/ESTAB MOD-HI 60 MIN CPT4 99245 OFC CNSLT NEW/ESTAB MOD-HI 80 MIN CPT4 99381 INIT PREV MED E&M NEW PT; INFANT CPT4 99382 INIT PREV MED E&M NEW PT; 1-4 YRS CPT4 99383 INIT PREV MED E&M NEW PT; 5-11 YRS CPT4 99384 INIT PREV MED E&M NEW PT; 12-17 YRS CPT4 99385 INIT PREV MED E&M NEW PT; 18-39 YRS

	CPT4 99386 INIT PREV MED E&M NEW PT; 40-64 YRS CPT4 99387 INIT PREV MED E&M NEW PT; 65 YRS/> CPT4 99391 PRD PREV MED E&M EST PT; INFNT <1YR CPT4 99392 PRD PREV MED E&M EST PT; 1-4 YRS CPT4 99393 PRD PREV MED E&M EST PT; 5-11 YRS CPT4 99394 PRD PREV MED E&M EST PT; 12-17 YRS CPT4 99395 PRD PREV MED E&M EST PT; 18-39 YRS CPT4 99396 PRD PREV MED E&M EST PT; 40-64 YRS CPT4 99397 PRD PREV MED E&M ESTAB PT; 65 YRS/> Tympanostomy Tube Insertion (Procedure) ========== Type Code Description ------- ------- ---------- CPT4 69433 TYMPANOSTOMY LOCAL/TOP ANESTHESIA CPT4 69436 TYMPANOSTOMY GENERAL ANESTHESIA ICD9P 2001 MYRINGOTOMY WITH INSERTION OF TUBE
6 (2a, 2d)	**Denominator Exclusions:** None **Denominator Exclusion Details** (Definitions, codes with description):
7 (2a, 2h)	**Stratification** Do the measure specifications require the results to be stratified? No ► If "other" describe: **Identification of stratification variable(s):** **Stratification Details** (Definitions, codes with description):
8 (2a, 2e)	**Risk Adjustment** Does the measure require risk adjustment to account for differences in patient severity before the onset of care? No ► **If yes,** (select one) ► Is there a separate proprietary owner of the risk model? (select one) **Identify Risk Adjustment Variables:** **Detailed risk model:** attached ☐ **OR** Web page URL:
9 (2a)	**Type of Score:** Rate/proportion **Calculation Algorithm:** attached ☐ **OR** Web page URL: **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 ► If "Other", please describe:
10 (2a. 4a, 4b)	**Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** diagnosis, procedure **Data dictionary/code table** attached ☒ **OR** Web page URL: **Data Quality** (2a) *Check all that apply* ☐ Data are captured from an authoritative/accurate source (e.g., lab values from laboratory personnel) ☒ Data are coded using recognized data standards ☐ Method of capturing data electronically fits the workflow of the authoritative source ☐ Data are available in EHRs ☒ Data are auditable
11 (2a, 4b)	**Data Source and Data Collection Methods** *Identifies the data source(s) necessary to implement the measure specifications. Check all that apply* ☐ Electronic Health/Medical Record ☐ Electronic Clinical Database, Name: ☐ Electronic Clinical Registry, Name: ☒ Electronic Claims ☐ Electronic Pharmacy data ☐ Paper Medical Record ☐ Standardized clinical instrument, Name: ☐ Standardized patient survey, Name: ☐ Standardized clinician survey, Name: ☒ Other, Describe: It is reasonable to allow physicians

	☐ Electronic Lab data ☐ Electronic source – other, Describe: to submit definitive evidence that a particular service was provided to a patient. For example, a lab result from a testing facility would indicate that that lab test was performed. A notation in a patient chart that the test was ordered, in contrast, would not provide definitive evidence that the test was performed. Instrument/survey attached ☐ **OR** Web page URL:
12 (2a)	**Sampling** *If measure is based on a sample, provide instructions and guidance on sample size.* **Minimum sample size:** 10 **Instructions:** We have developed a hierarchical logistic regression model with expert biostatisticians at the Johns Hopkins School of Public Health that enables one to produce a probability distribution around a point estimate of the "quality score" for a given physician. This model has shown that there is no minimum sample size that is required to produce a quality score which has a comparatively "tight" probability distribution. Rather, the number of required observations depends on how a given physician performs on particular measures compared to how all other MDs perform on those measures. We recommend that a minimum of 10 observations be required, however, because of the normality assumptions that underlies the model and for public "face validity". Alternatively, to satisfy current NCQA standards, a minimum of 30 observations could be required.
13 (2a)	**Type of Measure:** Process ► If "Other", please describe: ► If part of a composite or paired with another measure, please identify composite or paired measure
14 (2a)	**Unit of Measurement/Analysis** (*Who or what is being measured*) *Check all that apply.* ☐ Can be measured at all levels ☒ Individual clinician (e.g., physician, nurse) ☒ Group of clinicians (e.g., facility department/unit, group practice) ☐ Facility (e.g., hospital, nursing home) ☒ Integrated delivery system ☒ Health plan ☒ Community/Population ☐ Other (*Please describe*):
15 (2a)	**Applicable Care Settings** *Check all that apply* ☐ Can be used in all healthcare settings ☒ Ambulatory Care (office/clinic) ☐ Behavioral Healthcare ☒ Community Healthcare ☐ Dialysis Facility ☐ Emergency Department ☐ EMS emergency medical services ☒ Health Plan ☐ Home Health ☐ Hospice ☐ Hospital ☐ Long term acute care hospital ☐ Nursing home/ Skilled Nursing Facility (SNF) ☐ Prescription Drug Plan ☐ Rehabilitation Facility ☐ Substance Use Treatment Program/Center ☐ Other (*Please describe*):
	IMPORTANCE TO MEASURE AND REPORT
	Note: This is a threshold criterion. If a measure is not judged to be sufficiently important to measure and report, it will not be evaluated against the remaining criteria.
16	**Addresses a Specific National Priority Partners Goal** *Enter the numbers of the specific goals related*

(1a)	*to this measure (see list of goals on last page)*: 6.1
17 (1a)	**If not related to NPP goal, identify high impact aspect of healthcare** (select one) **Summary of Evidence:** **Citations[2] for Evidence:**
18 (1b)	**Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.* **Summary of Evidence:** Numerator denominator proportion --- 37 51 72.55% 319 402 79.35% 363 439 82.69% 15 18 83.33% 61 71 85.92% 115 128 89.84% **Citations for Evidence:** RHI client experience
19 (1b)	**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.* **Summary of Evidence:** **Citations for evidence:**
20 (1c)	**If measuring an Outcome** Describe relevance to the national health goal/priority, condition, population, and/or care being addressed: **If not measuring an outcome, provide evidence supporting this measure topic and grade the strength of the evidence** *Summarize the evidence (including citations to source) supporting the focus of the measure as follows:* • Intermediate outcome – evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit. • Process – evidence that the measured clinical or administrative process leads to improved health/avoidance of harm and if the measure focus is on one step in a multi-step care process, it measures the step that has the greatest effect on improving the specified desired outcome(s). • Structure – evidence that the measured structure supports the consistent delivery of effective processes or access that lead to improved health/avoidance of harm or cost/benefit. • Patient experience – evidence that an association exists between the measure of patient experience of health care and the outcomes, values and preferences of individuals/ the public. • Access – evidence that an association exists between access to a health service and the outcomes of, or experience with, care. • Efficiency– demonstration of an association between the measured resource use and level of performance with respect to one or more of the other five IOM aims of quality. **Type of Evidence** *Check all that apply* ☒ Evidence-based guideline ☐ Quantitative research studies ☐ Meta-analysis ☐ Qualitative research studies ☐ Systematic synthesis of research ☐ Other (*Please describe*): **Overall Grade for Strength of the Evidence[3]** (*Use the USPSTF system, or if different, also describe how it relates to the USPSTF system)*: See below **Summary of Evidence** (*provide guideline information below*)**:** **Citations for Evidence:** See question #21 below

[2] Citations can include, but are not limited to journal articles, reports, web pages (URLs).

21 (1c)	**Clinical Practice Guideline** *Cite the guideline reference; quote the specific guideline recommendation related to the measure and the guideline author's assessment of the strength of the evidence; and summarize the rationale for using this guideline over others.* **Guideline Citation:** Acute Otitis Externa (AOE)/Otitis Media with Effusion (OME) Physician Performance Measurement Set. American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS) Foundation/Physician Consortium for Performance Improvement. March 2007. **Specific guideline recommendation:** Otitis media with effusion (OME) is often accompanied by hearing loss which can impair early language acquisition, especially in severe cases which often necessitate tympanostomy tube insertion. Therefore, it is imperative that any patient for whom tympanostomy tube insertion is indicated have their hearing tested. **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF*)**:** Recommendation based on cohort studies and preponderance of benefit over risk. [Aggregate evidence quality – Grade B and C]) **Rationale for using this guideline over others:**
22 (1c)	**Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.* **Summary:** **Citations:**
23 (1)	**Briefly describe how this measure (as specified) will facilitate significant gains in healthcare quality related to the specific priority goals and quality problems identified above:** By identifying specific patients in whom care is not consistent with the clinical practice guideline underlying the measure, the measure will facilitate improvement in the care for those patients by highlighting the patient-specific QI opportunity for the patient's physician(s). In addition, the feedback physicians will receive on their overall performance on this measure will help focus their attention on the underlying care issue and improve their performance on that issue across all of their patients. If performance measurement is combined with some sort of financial incentive, such as in a pay for performance program, the QI impact may be increased.
	SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES
	Note: Testing and results should be summarized in this form. However, additional detail and reports may be submitted as supplemental information or provided as a web page URL. If a measure has not been tested, it is only potentially eligible for time-limited endorsement.
24	**Supplemental Testing Information:** attached ☐ **OR** Web page URL:
25 (2b)	**Reliability Testing** **Data/sample:** We have tested this measure on several patient populations, including, in total, more than 30 million people enrolled in 18 different health plans. In addition, we have used analogous computer algorithms to identify patient-specific QI opportunities in more than 5 million health plan members and have sent messages regarding those opportunities to either the member or the member's physician or both.

[3]The strength of the body of evidence for the specific measure focus should be systematically assessed and rated, e.g., USPSTF grading system www.ahrq.gov/clinic/uspstmeth.htm: A - The USPSTF recommends the service. There is high certainty that the net benefit is substantial. B - The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. C - The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. Offer or provide this service only if other considerations support the offering or providing the service in an individual patient. D - The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. I - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

	Analytic Method: The validity of a physician quality score describes how accurately it estimates the true value. Reliability is the stability or consistency of an estimator from one data set to the next. Both are important in assessing the performance of the quality score. We have used the following measure as an indication of the reliability of each of our measures: 1 minus [(the variance of the posterior distribution of the physician quality score) divided by (the variance of the true physician quality score)], which is the reduction in the variance of a doctor's performance score (posterior distribution) obtained by using his or her performance data, expressed as a fraction of the total variance before any data is collected. **Testing Results:** The reliability of a physician quality score depends on the number of observations available for a given physician, how the physician performs relative to all other physician, and the overall variance in physician quality scores. As a result, reliability varies with the population of MDs in whom the measure is used. In our experience, reliability is in the range of 0.5 to >0.7.
26 (2c)	**Validity Testing** **Data/sample:** We have tested this measure on several patient populations, including, in total, more than 30 million people enrolled in 18 different health plans. In addition, we have used analogous computer algorithms to identify patient-specific QI opportunities in more than 5 million health plan members and have sent messages regarding those opportunities to either the member or the member's physician or both. **Analytic Method:** We have employed several approaches to ensure the validity of this measure: 1) we've ensured that the technical specifications for this measure are valid reflections of the underlying clinical practice guideline; 2) we have obtained feedback on the validity of the measure from several physician panels that were assembled by either Care Focused Purchasing or the Massachusetts Group Insurance Commission Clinical Performance Improvement Initiative, or both, and 3) we have systematically collected feedback from physicians and health plan members to whom we have sent messages regarding this measure. **Testing Results:** This measure is considered to be valid by the physician panels that have reviewed it. (More information regarding the panels is provided elsewhere in this document.) In addition, the measure has been considered to be valid by the medical directors of 17 different health plans. In addition, the fact that thousands of physicians have received results based on this measure without indicating that they don't believe the measure is valid attests to its validity.
27 (2d)	**Measure Exclusions** *Provide evidence to justify exclusion(s) and analysis of impact on measure results during testing.* **Summary of Evidence supporting exclusion(s):** n/a **Citations for Evidence:** **Data/sample:** **Analytic Method:** **Testing Results:**
28 (2e)	**Risk Adjustment Testing** *Summarize the testing used to determine the need (or no need) for risk adjustment and the statistical performance of the risk adjustment method.* **Data/sample:** **Analytic Method:** **Testing Results:** ►**If outcome or resource use measure not risk adjusted, provide rationale:** There is no need to risk adjust results from this measure. To the extent that the measure applies only to patients in a particular

	risk category, that has been taken into account in the specifications for the denominator or exclusions for this measure.
29 (2g)	**Testing comparability of results when more than 1 data method is specified** (*e.g., administrative claims or chart abstraction*) **Data/sample:** **Analytic Method:** **Results:**
30 (2f)	**Provide Measure Results from Testing or Current Use** Results from current use **Data/sample:** Group Insurance Commission (GIC): In 2003, the Massachusetts Group Insurance Commission GIC launched the Clinical Performance Improvement initiative, requiring health plans under contract with the GIC to incorporate provider "tiering"—differential payments based on value—into their GIC product. For this initiative, RHI evaluates physician performance on a set of quality measures using administrative claims data from approximately 2.2 million health plan members. **Methods to identify statistically significant and practically/meaningfully differences in performance:** We have developed a hierarchical logistic regression model with expert biostatisticians at the Johns Hopkins School of Public Health that enables one to produce a probability distribution around a point estimate of the "quality score" for a given physician. This model has shown that there is no minimum sample size that is required to produce a quality score which has a comparatively "tight" probability distribution. Rather, the number of required observations depends on how a given physician performs on particular measures compared to how all other MDs perform on those measures. We recommend that a minimum of 10 observations be required, however, because of the normality assumption that underlies the model and for public "face validity". We have employed this statistical approach in the MD quality profiling we performed on the experience of more than 2 million members of 6 health plans participating in the Massachusetts Group Insurance Commission Clinical Performance Improvement Initiative in 2008. **Results:** Pooled results: numerator denominator proportion --- 910 1,109 82.06%
31 (2h)	**Identification of Disparities** ►If measure is stratified by factors related to disparities (i.e. race/ethnicity, primary language, gender, SES, health literacy), **provide stratified results:** Not applicable ►If disparities have been reported/identified, but measure is not specified to detect disparities, provide rationale:
	USABILITY
32 (3)	**Current Use** In use **If in use, how widely used** State ► If "other," please describe: ☒ Used in a public reporting initiative, name of initiative: Group Insurance Commission of Massachusetts, Clinical Performance Improvement Initiative Sample report attached ☐ **OR** Web page URL:
33 (3a)	**Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **Data/sample:** We have tested this measure on several patient populations, including, in total, more than 30 million people enrolled in 18 different health plans.

	Methods: The results have been provided to the medical directors of the 18 health plans, all of whom have indicated that they understand the particular aspect of care that the measure addresses and how to interpret the result for a physician. In addition, results have been presented to HR directors from >60 national employers. **Results:** Both the health plan medical directors and the HR personnel from the employers have indicated that they understand the particular aspect of care that the measure addresses and how to interpret the result for a physician. We do not have data on the extent to which individual physicians understand the measure result, but we presume that, since health plan medical directors and non-medical personnel from employers understand the result, that physicians and lay people will also so long that adequate explanation is provided.
34 (3b, 3c)	**Relation to other NQF-endorsed™ measures** ►Is this measure similar or related to measure(s) already endorsed by NQF (on the same topic or the same target population)? *Measures can be found at www.qualityforum.org under Core Documents.* *Check all that apply* ☐ Have not looked at other NQF measures ☐ Other measure(s) on same topic ☐ Other measure(s) for same target population ☒ No similar or related measures **Name of similar or related NQF-endorsed™ measure(s):** **Are the measure specifications harmonized with existing NQF-endorsed™ measures?** (select one) ►If not fully harmonized, provide rationale: **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** This measure can be used exclusively with enriched administrative data.
	FEASIBILITY
35 (4a)	**How are the required data elements generated?** *Check all that apply* ☐ Data elements are generated concurrent with and as a byproduct of care processes during care delivery (e.g., blood pressure or other assessment recorded by personnel conducting the assessment) ☐ Data elements are generated from a patient survey (e.g., CAHPS) ☒ Data elements are generated through coding performed by someone other than the person who obtained the original information (e.g., DRG or ICD-9 coding on claims) ☐ Other, Please describe:
36 (4b)	**Electronic Sources** All data elements ►**If all data elements are not in electronic sources, specify the near-term path to electronic collection by most providers:** ►**Specify the data elements for the electronic health record:**
37 (4c)	**Do the specified exclusions require additional data sources beyond what is required for the other specifications?** No ►**If yes, provide justification:**
38 (4d)	**Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure:** As with any type of clinical performance measure, and with any source of data used to operationalize the measure, there will be some instances in which the data used to compute the measure are incomplete or inaccurate. We try to minimize the impact of such errors or omissions through the way we have constructed the technical specifications for the measure. There is no data source for performance measurement that is completely accurate. Two studies have shown that physician performance tends to be better when assessed using claims data compared to via chart abstraction. **Describe how could these potential problems be audited:** Potential data errors of omission or commission could be audited through chart abstraction, or feedback from physicians and patients. However, as mentioned above, each of these alternative sources of information also are susceptible to error and thus are not true gold standards.

	Did you audit for these potential problems during testing? Yes **If yes, provide results:** Through feedback from physicians whose performance has been evaluated.
39 (4e)	**Testing feasibility** Describe what have you learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: The technical specifications for all of our measures have been reviewed over time by numerous physicians and have been adjusted when feedback has indicated a way to improve the measure. Our experience suggests that the only practical and affordable approach for evaluation of the performance of individual MDs on a large scale is through use of claims data. We have found there to be benefit from determining whether a particular health plan has capitated arrangements with physicians or other types of providers (e.g. labs and radiology facilities) in a particular geographic area and, in those instances, to only include observations if encounter data are available. We routinely require at least 4 months of "claims runout" after the end of a measurement year in order to take account of claim lag.
	CONTACT INFORMATION
40	**Web Page URL for Measure Information** *Describe where users (implementers) should go for more details on specifications of measures, or assistance in implementing the measure.* **Web page URL:** *www.resolutionhealth.com*
41	**Measure Intellectual Property Agreement Owner Point of Contact** **First Name:** Alan **MI:** **Last Name:** Lefkowitz **Credentials (MD, MPH, etc.):** **Organization:** Resolution Health **Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044 **Email:** alefkowitz@resolutionhealth.com **Telephone:** 240-295-5834 ext:
42	**Measure Submission Point of Contact** **If different than IP Owner Contact** **First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP **Organization:** Resolution Health **Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044 **Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext:
43	**Measure Developer Point of Contact** **If different than IP Owner Contact** **First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP **Organization:** Resolution Health **Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044 **Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext:
44	**Measure Steward Point of Contact** **If different than IP Owner Contact** *Identifies the organization that will take responsibility for updating the measure and assuring it is consistent with the scientific evidence and current coding schema; the steward of the measure may be different than the developer.* **First Name:** Darren **MI:** M **Last Name:** Schulte **Credentials (MD, MPH, etc.):** MD, MPP **Organization:** Resolution Health **Street Address:** 10490 Little Patuxent Parkway **City:** Columbia **State:** MD **ZIP:** 21044 **Email:** dschulte@resolutionhealth.com **Telephone:** 650-773-3308 ext:
	ADDITIONAL INFORMATION
45	**Workgroup/Expert Panel involved in measure development** Workgroup/panel used ►If workgroup used, describe the members' role in measure development: Over the past several years, two formal workgroups -- one organized by the Care Focused Purchasing initiative and one organized by the Massachusetts Group Insurance Commission Clinical Performance Improvement Initiative -- and several ad hoc experts have provided useful input to our measure development and refinement processes. In each case, we have provided the Work Group Members with details regarding each of our performance measures and members of the work group (not always all members) have provided feedback on the validity of the clinical practice guideline underlying the measure and suggestions regarding potential ways to improve the technical specifications for the measure. In some instances, we have eliminated measures

	based on feedback from the work groups. In other instances, work group members have proposed new measures. We try to get feedback from work group members and selected clinical experts on an annual basis. ►Provide a list of workgroup/panel members' names and organizations: Care Focused Purchasing Clinical Advisory Panel: Bobbie Berg -BCBS -IL Dow Briggs - BCBS- AL Joe Calderella - Cigna Carl Cameron - Preferred Care Steven Goldberg – Humana Tom James – Humana Don Liss – Aetna Catherine MacLean – WellPoint Zak Ramadan–Jradi – Regence Fred Volkman – Avidyn Health Connie Hwang – Resolution Health Darren Schulte - Resolution Health Massachusetts Group Insurance Commission Physician Advisory Panel: Jim Glauber – Neighborhood Health Plan Lyn Laurenco - Neighborhood Health Plan Anton Dodek - Tufts Barbara Chase - Fallon Jonathan Scott Coblyn – Brigham and Women's Hospital Tom Ebert - Health New England Elaine Wilson - Harvard Pilgrim Health Care Jennifer St. Thomas – Tufts Jennifer Lavigne – Fallon Michael O'Shea - Baycare Health Neil Minkoff - Harvard Pilgrim Health Care Paul Mendis- Neighborhood Health Plan Bob Jordan - Neighborhood Health Plan Bob Sorrenti – Unicare Constance Williams – Unicare Laura Syron - Neighborhood Health Plan Susan Tiffany – Unicare Connie Hwang – Resolution Health Darren Schulte - Resolution Health David Gregg – Mercer Russ Robinson - Mercer
46	**Measure Developer/Steward Updates and Ongoing Maintenance** Year the measure was first released: 2008 Month and Year of most recent revision: October 2008 What is the frequency for review/update of this measure? Annual Review When is the next scheduled review/update for this measure? Summer 2009
47	**Copyright statement/disclaimers:** Copyright © 2008 – Resolution Health, Inc. All rights reserved. The material submitted is confidential and proprietary. No use of this material is permitted other than in accordance with the Agreement with Measure Stewards between National Quality Forum and Resolution Health, Inc.
48	**Additional Information:** None
49	**I have checked that the submission is complete and any blank fields indicate that no information is provided.** ☒
50	**Date of Submission** (*MM/DD/YY*)**:** 11/20/08

PATIENT & FAMILY ENGAGEMENT

PRIORITY STATEMENT: Engage Patients and Their Families in Managing Their Health and Making Decisions About Their Care

1.1. All providers will routinely solicit and publicly report on their patients' perspectives of care

1.2. All providers will work collaboratively with their patients to assist them in making informed decisions about treatment options consistent with their values and preferences

POPULATION HEALTH

PRIORITY STATEMENT: IMPROVE THE HEALTH OF THE U.S. POPULATION

2.1. The population will be up to date on all high-priority age- and gender-appropriate evidence-based clinical preventive services

2.2. The population will receive recommended evidence-based interventions to improve targeted healthy lifestyle behaviors

2.3. All communities will demonstrate a 10% improvement in their community index of health

2.4. Americans will have all recommended high priority healthy lifestyle behaviors under control

SAFETY

PRIORITY STATEMENT: IMPROVE THE SAFETY OF THE U.S. HEALTH CARE SYSTEM

3.1. All providers will drive all preventable healthcare-associated infections (HAI) to zero

3.2. All providers will drive the incidence of preventable NQF Serious Reportable Events (SRE) to zero

3.3. All hospitals will reduce preventable and premature mortality rates to best-in-class

3.4. All hospitals and their community partners will reduce 30-day mortality rates following hospitalization for select conditions to best-in-class

PALLIATIVE CARE

PRIORITY STATEMENT: GUARANTEE APPROPRIATE AND COMPASSIONATE CARE FOR PATIENTS WITH LIFE-LIMITING ILLNESSES

4.1. All providers will identify, document, and effectively treat physical symptoms (e.g. pain, shortness of breath, constipation, others) at levels acceptable to patients with a life-limiting illness

4.2. All providers will effectively address the psychosocial and spiritual needs of patients with life-limiting illnesses and their families according to their preferences

4.3. All eligible patients will receive high quality palliative care and hospice services

CARE COORDINATION

PRIORITY STATEMENT: ENSURE PATIENTS RECEIVE WELL-COORDINATED CARE ACROSS ALL PROVIDERS, SETTINGS, AND LEVELS OF CARE

5.1. All providers will accurately and completely reconcile medications across the continuum of care (i.e. admission, transfer within and between care providers, discharge, and outpatient appointments) and ensure communication with the next provider of services

5.2. All inpatient and outpatient providers will assess the patient's perspective of the coordination of their care using a validated care coordination survey tool

5.3. All providers will reduce 30-day all-cause readmission rates resulting from poorly coordinated care to best-in-class

5.4. All providers will reduce preventable emergency department (i.e. those that could be avoided with timely access to primary care) visits resulting from poorly coordinated care by 50%

PATIENT-FOCUSED CARE

PRIORITY STATEMENT: GUARANTEE HIGH VALUE CARE ACROSS ACUTE AND CHRONIC EPISODES

6.1. All patients will receive high-value care over the course of their acute or chronic illness

OVERUSE

PRIORITY STATEMENT: ELIMINATE WASTE WHILE ENSURING THE DELIVERY OF APPROPRIATE CARE

7.1. Reduce wasteful and inappropriate care for the top ten targeted areas by 50%