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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	(for NQF staff use) *NQF Review #: EC-239-08* *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): 6/25/09*
2	*Title of Measure: GERD - Upper Gastrointestinal Study in Adults with Alarm Symptoms*
3	**Brief description of measure [1]:** Percentage of patients with gastroesophogeal reflux disease (GERD)with alarm symptoms and who have had an upper gastrointestinal study
4 (2a)	**Numerator Statement:** Patients who have had an upper gastrointestinal study **Time Window:** 12 months **Numerator Details** (Definitions, codes with description): see attached
5 (2a)	**Denominator Statement:** Patients diagnosed with GERD with alarm symptoms (e.g., dysphagia, iron deficiency anemia, weight loss) **Time Window:** 12 months **Denominator Details** (Definitions, codes with description): see attached
6 (2a, 2d)	**Denominator Exclusions:** P1. Patients with a documented gastrointestinal malignancy 2. Metastatic malignancy, chemotherapy/radiation therapy, hospice and SNF 3. Patients with other causes of the alarm symptoms, including end-stage renal disease, scleroderma, cystic fibrosis, esophageal varices, known Barrett's esophagus, or gastric restrictive procedures **Denominator Exclusion Details** (Definitions, codes with description): see attached
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:**

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

	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)**:** ICD9, CPT, pharmacy claims, lab values **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 (1a)	**Addresses a Specific National Priority Partners Goal** *Enter the numbers of the specific goals related to this measure (see list of goals on last page)*: 2.1,2.2
17 (1a)	**If not related to NPP goal, identify high impact aspect of healthcare** (select one) **Summary of Evidence:** The 2005 American College of Gastroenterology guidelines for the diagnosis and treatment of gastroesophgeal reflux disease offer a specific evidence review and diagnostic guideline for use of endoscopy in GERD. Their recommendation, specifically, is that "Endoscopy is the technique of choice used to identify suspected Barrett's esophagus and to diagnose complications of GERD. Biopsy must be added to confirm the presence of Barrett's epithelium and to evaluate for dyspepsia." The ACG cites the Level of Evidence as "III" supporting this recommendation, which refers to evidence from published well-designed trials without randomization, single group pre-post, cohort, time series or matched case-controlled studies. The authors of the guideline cite evidence suggesting the limitations of the usefulness of barium radiography, and furthermore the issues surrounding the need to determine the presence of Barrett's epithelium. In an earlier guideline, the ACG also notes specific warning symptoms suggesting complicated GERD, including dysphagia, bleeding, weight loss, choking (acid causing coughing, shortness of breath, or hoarseness) and chest pain. The ASGE/ACG Task force on Quality in Endoscopy notes, in the 2006 Quality Indicators for Endoscopy, a set of indications for endoscopy, which also contains these warning symptoms. Katz (1999) notes evidence supporting the prevalence of severe compilcations in GERD, including strictures (2-10% of GERD patients) and Barrett's esophagus (9-12%). In our book of business experience since 2002, a total of 733 clinical alerts were sent for members with GERD and warning symptoms who had not yet undergone EGD. Follow-up data showed that 19% of members had undergone follow-up testing related to the alert. **Citations[2] for Evidence:** Updated Guidelines for the Diagnosis and Treatment of Gastroesophageal Reflux Disease. Am J Gastroenterol 2005;100:190-200. Accessed online at http://gi.org/physicians/guidelines/GERDTreatment.pdf on 2/1/09. Updated Guidelines for the Diagnosis and Treatment of Gastroesophageal Reflux Disease. Am J Gastroenterol 1999;94:1434-1442. Cohen JC et al. Quality Indicators for Esophagogastroduodenoscopy. Am J Gastroenterol 2006;101:886–891. Katz PO. Treatment of gastroesophageal reflux disease: use of algorithms to aid in management. Am J Gastroenterol. 1999;94:S3-10
18 (1b)	**Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.* **Summary of Evidence:** In our book of business experience since 2002, a total of 733 clinical alerts were sent for members with GERD and warning symptoms who had not yet undergone EGD. Follow-up data showed that 19% of members had undergone follow-up testing related to the alert. Measures in actual populations or provider groups have not yet appeared in the peer-reviewed literature, although a similar measure was approved from the Physician Consortium, titled "upper endoscopy for patients with alarm symptoms." **Citations for Evidence:** ---

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

19 (1b)	**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.* **Summary of Evidence:** Measures in actual populations or provider groups, including disparities-releated studies and research, have not yet appeared in the peer-reviewed literature, although a similar measure was approved from the Physician Consortium, titled "upper endoscopy for patients with alarm symptoms." **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)*: Level III - well-designed trials without randomization, cohort and case-controlled studies **Summary of Evidence** (*provide guideline information below*)**:** The 2005 American College of Gastroenterology guidelines for the diagnosis and treatment of gastroesophgeal reflux disease offer a specific evidence review and diagnostic guideline for use of endoscopy in GERD. Their recommendation, specifically, is that "Endoscopy is the technique of choice used to identify suspected Barrett's esophagus and to diagnose complications of GERD. Biopsy must be added to confirm the presence of Barrett's epithelium and to evaluate for dyspepsia." The ACG cites the Level of Evidence as "III" supporting this recommendation, which refers to evidence from published well-designed trials without randomization, single group preopost, cohort, time series or matched case-controlled studies. The authors of the guideline cite evidence suggesting the limitations of the usefulness of barium radiography, and furthermore the issues surrounding the need to determine the presence of Barrett's epithelium.

[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.

	In an earlier guideline, the ACG also notes specific warning symptoms suggesting complicated GERD, including dysphagia, bleeding, weight loss, choking (acid causing coughing, shortness of breath, or hoarseness) and chest pain. The ASGE/ACG Task force on Quality in Endoscopy notes, in the 2006 Quality Indicators for Endoscopy, a set of indications for endoscopy, which also contains these warning symptoms. Katz (1999) notes evidence supporting the prevalence of severe compilcations in GERD, including strictures (2-10% of GERD patients) and Barrett's esophagus (9-12%). In our book of business experience since 2002, a total of 733 clinical alerts were sent for members with GERD and warning symptoms who had not yet undergone EGD. Follow-up data showed that 19% of members had undergone follow-up testing related to the alert **Citations for Evidence:** Updated Guidelines for the Diagnosis and Treatment of Gastroesophageal Reflux Disease. Am J Gastroenterol 2005;100:190-200. Accessed online at http://gi.org/physicians/guidelines/GERDTreatment.pdf on 2/1/09. Updated Guidelines for the Diagnosis and Treatment of Gastroesophageal Reflux Disease. Am J Gastroenterol 1999;94:1434-1442. Cohen JC et al. Quality Indicators for Esophagogastroduodenoscopy. Am J Gastroenterol 2006;101:886–891. Katz PO. Treatment of gastroesophageal reflux disease: use of algorithms to aid in management. Am J Gastroenterol. 1999;94:S3-10
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:** Updated Guidelines for the Diagnosis and Treatment of Gastroesophageal Reflux Disease. Am J Gastroenterol 2005;100:190-200. Accessed online at http://gi.org/physicians/guidelines/GERDTreatment.pdf on 2/1/09. **Specific guideline recommendation:** The 2005 American College of Gastroenterology guidelines for the diagnosis and treatment of gastroesophgeal reflux disease offer a specific evidence review and diagnostic guideline for use of endoscopy in GERD. Their recommendation, specifically, is that "Endoscopy is the technique of choice used to identify suspected Barrett's esophagus and to diagnose complications of GERD. Biopsy must be added to confirm the presence of Barrett's epithelium and to evaluate for dyspepsia." **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)***:** The 2005 American College of Gastroenterology guidelines for the diagnosis and treatment of gastroesophgeal reflux disease offer a specific evidence review and diagnostic guideline for use of endoscopy in GERD. Their recommendation, specifically, is that "Endoscopy is the technique of choice used to identify suspected Barrett's esophagus and to diagnose complications of GERD. Biopsy must be added to confirm the presence of Barrett's epithelium and to evaluate for dyspepsia." Similar measures have also cited the Veterans Health Administration and ICSI guidelines: Further diagnostic testing (including endoscopy, proton pump inhibitor (PPI) trial, ambulatory pH monitoring, or other tests) is recommended in the following: • Patients with alarm symptoms (referral for further testing should be immediate). Alarm symptoms are those that suggest cancer. Alarm symptoms include dysphagia, odynophagia, weight loss, hematemesis, black or bloody stools, chest pain, or choking (acid reflux causing coughing, hoarseness, or shortness of breath). (Veterans Health Administration [VHA])

	ICSI Send patients with dyspepsia plus one of the following alarm features for urgent endoscopic evaluation. Suggested time frames for the urgency of endoscopy are provided with each of the alarm features listed. (Institute for Clinical Systems Improvement [ICSI]) • Melena (within 1 day if ill) • Hematemesis (within 1 day if ill) • Persistent vomiting (7-10 days) • Anemia (7-10 days) • Acute onset of total dysphagia (within 1 day) • Weight loss greater than 5% (involuntary) (7-10 days) **Rationale for using this guideline over others:** Nationally recognized guideline in gastroenterology
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:** Patients with GERD are at significant risk for Barrett's esophagus and other complications e.g. strictures. The presence of warning symptoms increases the probability of that these complications are present. The increased application of endoscopy to this high-risk subpopulation may increase the identification and decrease the risk for adverse outcome due to these complications, e.g. progression from Barrett's esophagus to esophageal malignancy.
	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:** **Analytic Method:** **Results:**
30 (2f)	**Provide Measure Results from Testing or Current Use** Results from testing **Data/sample:** We measured a population of 459,196 members. **Methods to identify statistically significant and practically/meaningfully differences in performance:** Compliance to the performance measure is measured using an analysis of the claims data; in this case looking for evidence of an H.pylori-related work-up. In addition, where appropriate we analyze patient data collected either from the patient's PHR or during a disease management program. **Results:** We found that of the 42 members who satisfied the denominator, 26 were in the numerator, indicating a compliance rate of 62%
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 Testing completed* *If in use, how widely used Health plan or sytem* ► *If "other," please describe:* ☐ *Used in a public reporting initiative, name of 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:** Administrative claims database from health plans; lab results data **Methods:** The performance measure is similar in message to a clinical alert that has been operational since 2002. Compliance to the clinical alert is measured using an analysis of subsequent claims, in this case the appearance of claims for H.pylori-related work-up. In addition, a feedback tool accompanies every clinical alert message, and includes options indicating agreement or disagreement with the message. **Results:** In practice, fewer than 1% of the respondents disagreed with the medical literature, and more than 19% show objective evidence of compliance.

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):** AGA Institute/Consortium/NCQA GERD Work Group (Work Group) Quality Measure: Endoscopy for patients with alarm symptoms; also known as Gastroesophageal reflux disease (GERD): percentage of patients aged 18 years and older seen for an initial evaluation of GERD with at least one alarm symptom who were either referred for upper endoscopy or had an upper endoscopy performed.. **Are the measure specifications harmonized with existing NQF-endorsed™ measures?** Partially harmonized ►If not fully harmonized, provide rationale: Denominator exclusions have been enhanced in the submitted measure **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** Denominator exclusions have been enhanced in the submitted measure, as well as validation of GERD diagnoses from claims and pharmacy 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: Data obtained through electronic personal health records and telephonic, nurse-driven disease management programs*
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: ICD9, CPT, NDC and LOINC codes*
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: Drugs obtained as samples or from third-party pharmacies may not appear in the claims data.* *Describe how could these potential problems be audited: The inclusion of patient-derived data from a personal health record or through a disease management program may be used to confirm the presence or absence of a medication; ultimately the data sources may be tested against a sample of medical charts.* *Did you audit for these potential problems during testing? No 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: Multiple sources of corroborating clinical data are necessary to correctly identify patients in the denominator. Earlier testing efforts using specifications similar to HEDIS were more sensitive yet*

	nonspecific. The additional of supporting information for certain diagnostic conditions (e.g., diabetic medications and supplies in addition to ICD9 codes for diabetes) significantly decreased the number identified in the denominator, yet the analysis led to a much higher compliance rate, likely because of the exclusion of fewer false positives in the denominator.
	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.activehealth.net*
41	**Measure Intellectual Property Agreement Owner Point of Contact** **First Name:** Madhavi **MI:** **Last Name:** Vemireddy **Credentials (MD, MPH, etc.):** MD **Organization:** ActiveHealth Management **Street Address:** 102 Madison Avenue **City:** New York **State:** NY **ZIP:** 10016 **Email:** mvemireddy@activehealth.net **Telephone:** 212-651-8200 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** No workgroup or panel used ►If workgroup used, describe the members' role in measure development: ►Provide a list of workgroup/panel members' names and organizations:
46	*Measure Developer/Steward Updates and Ongoing Maintenance* *Year the measure was first released: 2002* *Month and Year of most recent revision: 03/2009* *What is the frequency for review/update of this measure? Biennially* *When is the next scheduled review/update for this measure? 2011*
47	**Copyright statement/disclaimers:**
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*)**:** 02/09/09

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%

PERFORMANCE MEASURE RULE
GERD with Warning Symptoms - Evaluation with Upper Gastrointestinal Study

DENOMINATOR

All of the following are correct:

1. Age ≥ 18 Years
2. One of the following is correct:
    a. All of the following are correct:
        i. Presence of patient data confirming at least 1 PDD- GERD result in the past 12 months
        ii. Presence of patient data confirming at least 1 PDD- GERD WARNING SYMPTOMS result in the past 12 months
    b. All of the following are correct:
        i. Presence of at least 2 GERD diagnosis codes in the past 12 months
        ii. One of the following is correct:
            1. All of the following are correct:
                a. Presence of at least 1 FERRITIN ≤ 12 in the past 6 months
                b. Presence of at least 1 HEMOGLOBIN MONITORING < 10 in the past 6 months
            2. All of the following are correct:
                a. Presence of at least 2 PEPTIC ULCER DISEASE WITH GI HEM. diagnosis in the past 6 months

                Exclusion if one of the following is correct:

                i. Presence of at least 2 IBD diagnosis in the past 24 months
                ii. Presence of at least 1 COLONOSCOPY procedure in the past 6 months
            3. All of the following are correct:
                a. Presence of at least 2 DYSPHAGIA diagnosis in the past 6 months

                Exclusion if one of the following is correct:

i. Presence of at least 2 DYSPHAGIA - MISC. CAUSES diagnosis in the past 24 months

4. All of the following are correct:

    a. Presence of at least 2 WEIGHT LOSS diagnosis in the past 6 months

        Exclusion if one of the following is correct:

        i. Presence of at least 2 METASTATIC MALIGNANCY(INCL CHEMO/RADIATION) diagnosis in the past 12 months

        ii. Presence of at least 2 IBD diagnosis in the past 24 months

        iii. Presence of at least 2 SCLERODERMA diagnosis in the past 24 months

        iv. Presence of at least 2 CYSTIC FIBROSIS diagnosis in the past 24 months

        v. Presence of at least 1 GASTRIC RESTRICTIVE PROCEDURE in the past 24 months

5. All of the following are correct:

    a. Presence of at least 2 IRON DEFICIENCY ANEMIA NONDIETARY diagnosis codes in the past 6 months

        Exclusion if one of the following is correct:

        i. Presence of at least 2 IBD diagnosis in the past 24 months

        ii. Presence of at least 2 MENORRHAGIA diagnosis in the past 24 months

        iii. Presence of at least 1 FERRITIN > 50 in the past 12 months

        iv. Presence of at least 1 HEMATOCRIT > 35 in the past 12 months

        v. If CKD Stage 5 Validation is confirmed for the member (see below)

        vi. Presence of at least 1 COLONOSCOPY procedure in the past 6 months

3. One of the following is correct:

a. Presence of a current refill for PUD/GERD DRUGS with at least 3 refills in the past 6 months

b. Presence of patient data confirming a current refill for PUD/GERD DRUGS Drug with a 90 days grace period

DENOMINATOR EXCLUSIONS

1. Presence of at least 2 BARRETT'S ESOPHAGUS diagnosis in the past 24 months
2. Presence of at least 2 ESOPHAGEAL VARICES diagnosis in the past 24 months
3. Presence of at least 2 GASTROINTESTINAL MALIGNANCY diagnosis in the past 24 months

NUMERATOR

One of the following is correct

1. Presence of patient data confirming at least 1 PDD- EGD IN PAST 12 MTHS in the past 12 months
2. Presence of at least 1 EGD procedure in the past 12 months
3. Presence of at least 1 UPPER GI STUDY procedure in the past 12 months

Note: A 3 month time window has been added to certain timeframes in order to account for the inherent delay in the acquisition of administrative claims data.

Note: A current refill is defined as a refill in which the day supply of a drug extends into the end of the measurement window plus a grace period of 30 days.