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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August 2008

	(for NQF staff use) NQF Review #: EC-002-08 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): 11/21/08*
2	*Title of Measure:* *APPROPRIATE WORK UP PRIOR TO ENDOMETRIAL ABLATION PROCEDURE*
3	**Brief description of measure [1]:** To ensure that all women have endometrial sampling performed before undergoing an endometrial ablation.
4 (2a)	**Numerator Statement:** Women who received endometrial sampling or hysteroscopy with biopsy during the year prior to the index date. **Time Window:** The year prior to the index date. **Numerator Details** (Definitions, codes with description): Numerator Logic: A or (B and C) [A] Endometrial sampling or dilation and curettage during the year prior to the index date. CPT-4 Code(s): 58100, 58110, 58120, 58558, 56351* [B] Hysteroscopy during the year prior to the index date. CPT-4 Code(s): 58555 AND [C] Pathology specimen sent CPT-4 Code(s): 88305 * Code retired, but appropriate for retrospective analysis. Note: index date is defined as the first instance of denominator criterion A.
5 (2a)	**Denominator Statement:** Continuously enrolled women who had an endometrial ablation procedure during the measurement year. **Time Window:** The measurement year. **Denominator Details** (Definitions, codes with description): [GENDER] Women [CE] Women who were continuously enrolled during the year prior to the index date. A and GENDER and CE [A] Women who had an endometrial ablation procedure during the measurement year.

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

	CPT-4 code(s): 56356*, 58353, 58356, 58563, 0009T ICD-9 surgical proc code(s): 68.23 *Code retired, but appropriate for retrospective analysis Note: index date is defined as the first instance of denominator criterion A.
6 (2a, 2d)	**Denominator Exclusions:** Women who had an endometrial ablation procedure during the year prior to the index date. **Denominator Exclusion Details** (Definitions, codes with description): Women who had an endometrial ablation procedure during the year prior to the index date. Denominator Exclusion Logic: A [A] Women who had an endometrial ablation during the year prior to the index date. CPT-4 code(s): 56356, 58353, 58356, 58563, 0009T ICD-9 surgical proc code(s): 68.23 Note: index date is defined as the first instance of denominator criterion A.
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)**:** **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:

	☐ Electronic Lab data ☒ Electronic source – other, Describe: Member demographics and member enrollment data 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:** N/A
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)*: N/A
17 (1a)	**If not related to NPP goal, identify high impact aspect of healthcare** patient/societal consequences of poor quality **Summary of Evidence:** • Menorrhagia is defined by bleeding in excess of 80 mL per menstrual period.[1] However, since self-assessment of blood loss is often inaccurate,[1-4] treatment is based upon a patient's own perception of heavy bleeding.[5] • Population-based studies suggest that about 10% of all women and 22% of women over the age of 35 suffer from menorrhagia.[1, 6-8] • Menorrhagia results in significant economic implications; a 2002 cross-sectional study reported that women with heavy menstrual flow are only 72% as likely to report working and are more likely to utilize health care services than women with lighter or normal menstrual flows.[7, 9] **Citations[2] for Evidence:** 1. Hallberg, L., et al., Menstrual blood loss--a population study. Variation at different ages and attempts to define normality. Acta Obstet Gynecol Scand, 1966. 45(3): p. 320-51. 2. Warner, P.E., et al., Menorrhagia I: measured blood loss, clinical features, and outcome in women with heavy periods: a survey with follow-up data. Am J Obstet Gynecol, 2004. 190(5): p. 1216-23.

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

	3. Chimbira, T.H., A.B. Anderson, and A. Turnbull, Relation between measured menstrual blood loss and patient's subjective assessment of loss, duration of bleeding, number of sanitary towels used, uterine weight and endometrial surface area. Br J Obstet Gynaecol, 1980. 87(7): p. 603-9. 4. Higham, J.M. and R.W. Shaw, Clinical associations with objective menstrual blood volume. Eur J Obstet Gynecol Reprod Biol, 1999. 82(1): p. 73-6. 5. Lethaby, A., et al., Endometrial resection and ablation versus hysterectomy for heavy menstrual bleeding. Cochrane Database Syst Rev, 2000(2): p. CD000329. 6. Cole, S.K., W.Z. Billewicz, and A.M. Thomson, Sources of variation in menstrual blood loss. J Obstet Gynaecol Br Commonw, 1971. 78(10): p. 933-9. 7. Cote, I., P. Jacobs, and D.C. Cumming, Use of health services associated with increased menstrual loss in the United States. Am J Obstet Gynecol, 2003. 188(2): p. 343-8. 8. Gath, D., et al., Psychiatric disorder and gynaecological symptoms in middle aged women: a community survey. Br Med J (Clin Res Ed), 1987. 294(6566): p. 213-8. 9. Cote, I., P. Jacobs, and D. Cumming, Work loss associated with increased menstrual loss in the United States. Obstet Gynecol, 2002. 100(4): p. 683-7.
18 (1b)	**Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.* **Summary of Evidence:** We were unable to find any studies which examine the rate of endometrial biopsy prior to ablation. However, the mean rate for this measure across 8 geographically diverse commercial U.S.-based health plans, which include approximately 7.5 million patients, is 53.8%, demonstrating that there is much room for improvement in the rate of endometrial biopsy prior to endometrial ablation. **Citations for Evidence:** The above figures represent 2006-2007 unpublished data from multiple health plan databases available to Health Benchmarks®.
19 (1b)	**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.* **Summary of Evidence:** There is evidence of racial disparities with respect to survival from endometrial cancer. In a study utilizing the SEER database, it was noted that Blacks had a hazard ratio for death from endometrial cancer of 2.57 compared to Whites and were significnatly more likely to present with advanced stage disease.[1,2] **Citations for evidence:** 1. Yap OW, Matthews RP. Racial and ethnic disparities in cancers of the uterine corpus. J Natl Med Assoc. 2006 Dec;98(12): p. 1930-3. 2. Randall TC, Armstrong K. Differences in treatment and outcome between African-American and white women with endometrial cancer. J Clin Oncol. 2003 Nov 15;21(22): p. 4200-6.
20 (1c)	**If measuring an Outcome** Describe relevance to the national health goal/priority, condition, population, and/or care being addressed: N/A **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*)**:** B **Summary of Evidence** (*provide guideline information below*)**:** • Women with heavy menstrual bleeding are at an increased risk of uterine cancer and abnormal endometrial histology.[1] • Pipelle sampling of the endometrium is an excellent detection measure. A meta-analysis found that detection rates of endometrial cancer and hyperplasia using the Pipelle technique were between 91% and 99%, and reported a sensitivity of 81% and a specificity of greater than 98% for the technique.[2] • Endometrial ablation may delay detection of cancer because bleeding from persistent or regenerating endometrium may be obstructed behind scar tissue.[3] **Citations for Evidence:** 1. Ash, S.J., S.A. Farrell, and G. Flowerdew, Endometrial biopsy in DUB. J Reprod Med, 1996. 41(12): p. 892-6. 2. Dijkhuizen, F.P., et al., The accuracy of endometrial sampling in the diagnosis of patients with endometrial carcinoma and hyperplasia: a meta-analysis. Cancer, 2000. 89(8): p. 1765-72. 3. McCausland, A.M. and V.M. McCausland, Long-term complications of endometrial ablation: Cause, diagnosis, treatment, and prevention. J Minim Invasive Gynecol, 2007. 14(4): p. 399-406.
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:** Endometrial Ablation. ACOG Practice Bulletin 2007 [cited 2007 August 1, 2007]. **Specific guideline recommendation:** The American College of Obstetricians and Gynecologists (ACOG) recommends that "the endometrium of all candidates for endometrial ablation should be sampled and histopathologic results should be reviewed before the procedure." (Level of evidence based upon expert opinion).[1] **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)***:** Level of evidence based upon expert opinion **Rationale for using this guideline over others:** ACOG is the leading US organization in the field of obstetrics and gynecology and its guidelines are highly regarded within the medical community.
22 (1c)	**Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.* **Summary:** There is little controversy about the utility of performing an endometrial biopsy prior to endometrial ablation. If the biopsy were not performed prior to the ablation, there would be more patients suffering from a delay in diagnosis of endometrial malignancy. **Citations:** N/A

[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.

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:** Recommending that all patients undergo endometrial biopsy prior to endometrial ablation will ensure that there is no malignancy present prior to ablation. Given that the symptoms of menorrhagia that prompt endometrial ablation are so similar to those of endometrial carcinoma and that the ablation itself can mask the symptoms of malignancy, it is important to rule out carcinoma prior to ablation. The widespread use of this measure will lead to earlier diagnosis of endometrial cancer, which can lead to lower morbidity and cost.
	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:** Data from commercial health plans were used to generate rates of colonoscopy follow-up, according to the algorithm specified above. Included health plans range from 500,000 members to 1.7 million members. **Analytic Method:** Testing rates for Plans A, B and C were compared for stability over the course of two years. **Testing Results:** PLAN 2006 Rate 2007 Rate 2006 Denominator 2007 Denominator A 52.2% 52.6% 2,397 2,573 B 60.7% 59.0% 1,916 2,388 C 44.3% 46.3% 2,153 2,280 Intepretation: scores are stable across years.
26 (2c)	**Validity Testing** **Data/sample:** Data from commercial health plans were used to generate rates of colonoscopy follow-up, according to the algorithm specified above. Included health plans range from 150,000 members to 1.7 million members. **Analytic Method:** Rates of endometrial biopsy prior to ablation, as well as associated denominators (per the measure algorithm above) were calculated for 8 plans. **Testing Results:** PLAN RATE DENOMINATOR Plan A 51.5% 103 Plan B 65.7% 198 Plan C 60.7% 1916 Plan D 55.3% 1004 Plan E 60.7% 242 Plan F 40.3% 236 Plan G 44.3% 2153 Plan H 52.2% 2397 Average Rate: 53.8% Standard Deviation: 8.62 Average Denominator: 1031
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): Women who had an endometrial ablation procedure during the year prior to the index date: These are patients who are undergoing a repeat ablation procedure during the measurement year. Presumably, an endometrial biopsy would have been performed prior to the first endometrial ablation. It would be unfair to not provide credit to clinicians for not performing an endometrial biopsy prior to a repeat ablation. **Citations for Evidence:** N/A **Data/sample:** N/A **Analytic Method:** N/A **Testing Results:** N/A
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:** N/A **Analytic Method:** N/A **Testing Results:** N/A ►**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:** N/A **Analytic Method:** N/A **Results:** N/A
30 (2f)	**Provide Measure Results from Testing or Current Use** Results from testing **Data/sample:** See boxes 25 and 26 **Methods to identify statistically significant and practically/meaningfully differences in performance:** **Results:**
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:** N/A ►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 (select one)* ► *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: Data are reported as rates and denominator size. It was felt that no interpretability testing was needed. Based upon numerous interactions with health plans, performance based on denominator and rate are easily interpreted, as long as the populations captured in numerator, denominator and denominator exclusion are made explicit. **Methods:** N/A **Results:** N/A
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: ICD-9 diagnosis codes, ICD-9 Proc Codes, CPT-4 codes, HCPCS codes, UB revenue codes, NDC code, DRG 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: This is a administrative claims-based quality indicator with certain potential biases, including coding variation between providers and missing data. Nevertheless, administrative claims data is the widely available and has been used to effectively examine and document patterns of health care utilization, detect opportunities to improve quality of care, estimate incidence of disease, and even assess outcomes of pharmaceutical, radiological, and surgical procedures.* *Describe how could these potential problems be audited: HBI has developed an online tool (currently in use by several health plans), which allows physicians the opportunity to supplement their quality scores through self-report via a secured web site. Via this website, physicians are able to identify specific patients with whom they had an office visit during the measurement period and who reportedly did not have the indicated quality care. Physicians can then review their charts to verify whether in fact the quality care was performed. The physician can then manually enter corrections to the patient record via the website, indicating that the quality care was done. This data is subject to clinical review prior to*

	acceptance. The hybrid quality score (via administrative claims and self report) can be updated on a quarterly basis. *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:*
	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: N/A*
41	**Measure Intellectual Property Agreement Owner Point of Contact** **First Name:** Zak **MI:** **Last Name:** Ramadan-Jradi **Credentials (MD, MPH, etc.):** MD, MPH **Organization:** Health Benchmarks® **Street Address:** 21650 Oxnard St., Suite 550 **City:** Woodland Hills **State:** CA **ZIP:** 91367-7806 **Email:** zramadan@us.imshealth.com **Telephone:** 818-676-2820 ext:
42	**Measure Submission Point of Contact** **If different than IP Owner Contact** **First Name:** Karen **MI:** **Last Name:** Hsu **Credentials (MD, MPH, etc.):** MPH, MBA **Organization:** Health Benchmarks® **Street Address:** 21650 Oxnard St., Suite 550 **City:** Woodland Hills **State:** CA **ZIP:** 91367-7806 **Email:** khsu@us.imshealth.com **Telephone:** 541-550-7983 ext:
43	**Measure Developer Point of Contact** **If different than IP Owner Contact** **First Name:** Judy **MI:** Y **Last Name:** Chen **Credentials (MD, MPH, etc.):** MD, MSHS **Organization:** Health Benchmarks® **Street Address:** 21650 Oxnard St., Suite 550 **City:** Woodland Hills **State:** CA **ZIP:** 91367-7806 **Email:** judy.chen@us.imshealth.com **Telephone:** 818-676-2883 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: 2008* *Month and Year of most recent revision: January, 2008* *What is the frequency for review/update of this measure? Annually* *When is the next scheduled review/update for this measure? January, 2009*
47	**Copyright statement/disclaimers:** © 2008 Health Benchmarks® Confidential and Proprietary All Rights Reserved
48	**Additional Information:** N/A

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*)**:** 11/21/08

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%