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

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August 2008

	(for NQF staff use) NQF Review #: EC-041-08 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): 6/19/09*
2	*Title of Measure: Dyslipidemia new med 12-week lipid test*
3	**Brief description of measure [1]:** This measure identifies patients age 18 or older who started lipid-lowering medication during the measurement year and had a lipid panel checked within 3 months after starting drug therapy.
4 (2a)	**Numerator Statement:** Patients in the denominator who had a serum lipid panel drawn within 3 months following start of lipid-lowering therapy **Time Window:** See details **Numerator Details** (Definitions, codes with description): - >=1 lab claim for 'lipid panel' within 90 days after starting lipid-lowering medication **Lipid Panel (Procedure)** ========== Type Code Description ------- ------- ---------- CPT4 3011F LIPID PANEL DOC REV CPT4 3048F LDL-C <100 MG/DL CPT4 3049F LDL-C 100-129 MG/DL CPT4 3050F LDL-C Gd- 130 mg/dL CPT4 3050F LDL-C>= 130 MG/DL CPT4 80061 LIPID PANEL CPT4 82465 CHOLESTEROL SERUM/WHOLE BLOOD TOTAL CPT4 83700 LIPOPRO BLD, ELECTROPHORETIC CPT4 83701 LIPOPROTEIN BLD, HR FRACTION CPT4 83704 LIPOPROTEIN, BLD, BY NMR CPT4 83715 LIPOPROT BLD; ELEC-PHORE SEP&QUAN CPT4 83716 LIPOPROTEIN BLD; HI RES FRAC & QUAN CPT4 83718 LIPOPROT DIR MSR; HI DNSITY CHOL CPT4 83719 ASSAY OF BLOOD LIPOPROTEIN CPT4 83719 LIPOPROT DIR MSR; DIR MSR VLDL CHOL CPT4 83721 ASSAY OF BLOOD LIPOPROTEIN CPT4 83721 LIPOPROT DIR MSR; DIR MSR LDL CHOL
5 (2a)	**Denominator Statement:** Patients newly started on lipid-lowering therapy during the first 9 months of the measurement year **Time Window:** See Details **Denominator Details** (Definitions, codes with description): - Age >=18 years as of the end of the measurement year - AND have started treatment from 'lipid group' of drugs between 91 and 365 days prior to the end of the measurement year - AND have service eligibility from 0 to 90 days after starting the lipid-lowering medication

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

- AND have continuous use of lipid-lowering medication from 0 to 90 days after starting the medication

Lipid Group (Medispan Drug)

Type	GPI Code	Description
GPI	39100010002905	Cholestyramine Powder 4 GM/DOSE
GPI	39100010003005	Cholestyramine Powder Packets 4 GM
GPI	39100010102905	Cholestyramine Light Powder 4 GM/DOSE
GPI	39100010103005	Cholestyramine Light Powder Packets 4 GM
GPI	39100016100330	Colesevelam HCl Tab 625 MG
GPI	39100020100320	Colestipol HCl Tab 1 GM
GPI	39100020102705	Colestipol HCl Granules 5 GM
GPI	39100020103010	Colestipol HCl Granule Packets 5 GM
GPI	39200025000110	Fenofibrate Cap 50 MG
GPI	39200025000124	Fenofibrate Cap 150 MG
GPI	39200025000308	Fenofibrate Tab 40 MG
GPI	39200025000310	Fenofibrate Tab 48 MG
GPI	39200025000311	Fenofibrate Tab 50 MG
GPI	39200025000312	Fenofibrate Tab 54 MG
GPI	39200025000322	Fenofibrate Tab 120 MG
GPI	39200025000323	Fenofibrate Tab 145 MG
GPI	39200025000325	Fenofibrate Tab 160 MG
GPI	39200025100104	Fenofibrate Micronized Cap 43 MG
GPI	39200025100107	Fenofibrate Micronized Cap 67 MG
GPI	39200025100114	Fenofibrate Micronized Cap 130 MG
GPI	39200025100115	Fenofibrate Micronized Cap 134 MG
GPI	39200025100130	Fenofibrate Micronized Cap 200 MG
GPI	39200030000310	Gemfibrozil Tab 600 MG
GPI	39200030002900	Gemfibrozil Powder
GPI	39300030000320	Ezetimibe Tab 10 MG
GPI	39400010100310	Atorvastatin Calcium Tab 10 MG (Base Equivalent)
GPI	39400010100320	Atorvastatin Calcium Tab 20 MG (Base Equivalent)
GPI	39400010100330	Atorvastatin Calcium Tab 40 MG (Base Equivalent)
GPI	39400010100350	Atorvastatin Calcium Tab 80 MG (Base Equivalent)
GPI	39400030100120	Fluvastatin Sodium Cap 20 MG
GPI	39400030100140	Fluvastatin Sodium Cap 40 MG
GPI	39400030107530	Fluvastatin Sodium Tab SR 24 HR 80 MG
GPI	39400050000305	Lovastatin Tab 10 MG
GPI	39400050000310	Lovastatin Tab 20 MG
GPI	39400050000320	Lovastatin Tab 40 MG
GPI	39400050007510	Lovastatin Tab SR 24HR 10 MG
GPI	39400050007520	Lovastatin Tab SR 24HR 20 MG
GPI	39400050007530	Lovastatin Tab SR 24HR 40 MG
GPI	39400050007540	Lovastatin Tab SR 24HR 60 MG
GPI	39400060100305	Rosuvastatin Calcium Tab 5 MG
GPI	39400060100310	Rosuvastatin Calcium Tab 10 MG
GPI	39400060100320	Rosuvastatin Calcium Tab 20 MG
GPI	39400060100340	Rosuvastatin Calcium Tab 40 MG
GPI	39400065100320	Pravastatin Sodium Tab 10 MG
GPI	39400065100330	Pravastatin Sodium Tab 20 MG
GPI	39400065100340	Pravastatin Sodium Tab 40 MG
GPI	39400065100360	Pravastatin Sodium Tab 80 MG

GPI	39400075000310	Simvastatin Tab 5 MG
GPI	39400075000320	Simvastatin Tab 10 MG
GPI	39400075000330	Simvastatin Tab 20 MG
GPI	39400075000340	Simvastatin Tab 40 MG
GPI	39400075000360	Simvastatin Tab 80 MG
GPI	39409902156320	Aspirin Buff Tab 81 MG & Pravastatin Na Tab 20 MG Thera Pack
GPI	39409902156325	Aspirin Buff Tab 325 MG & Pravastatin Na Tab 20 MG Ther Pack
GPI	39409902156330	Aspirin Buff Tab 81 MG & Pravastatin Na Tab 40 MG Thera Pack
GPI	39409902156335	Aspirin Buff Tab 325 MG & Pravastatin Na Tab 40 MG Ther Pack
GPI	39409902156340	Aspirin Buff Tab 81 MG & Pravastatin Na Tab 80 MG Thera Pack
GPI	39409902457520	Niacin-Lovastatin Tab SR 24HR 500-20 MG
GPI	39409902457525	Niacin-Lovastatin Tab SR 24HR 750-20 MG
GPI	39409902457530	Niacin-Lovastatin Tab SR 24HR 1000-20 MG
GPI	39409902457535	Niacin-Lovastatin Tab SR 24HR 1000-40 MG
GPI	39409902707520	Niacin-Simvastatin Tab SR 24HR 500-20 MG
GPI	39409902707525	Niacin-Simvastatin Tab SR 24HR 750-20 MG
GPI	39409902707530	Niacin-Simvastatin Tab SR 24HR 1000-20 MG
GPI	39409908500120	*Misc Natural HMG CoA Reductase Inhibitors - Cap***
GPI	39450050000450	Niacin Tab CR 500 MG (Antihyperlipidemic)
GPI	39450050000460	Niacin Tab CR 750 MG (Antihyperlipidemic)
GPI	39450050000470	Niacin Tab CR 1000 MG (Antihyperlipidemic)
GPI	39500045200130	Omega-3-acid Ethyl Esters Cap 1 GM
GPI	39500050000120	Policosanol Cap 10 MG
GPI	39500050000320	Policosanol Tab 10 MG
GPI	39500055002900	Probucol Powder
GPI	39994002300320	Ezetimibe-Simvastatin Tab 10-10 MG
GPI	39994002300330	Ezetimibe-Simvastatin Tab 10-20 MG
GPI	39994002300340	Ezetimibe-Simvastatin Tab 10-40 MG
GPI	39994002300350	Ezetimibe-Simvastatin Tab 10-80 MG
GPI	40992502150305	Amlodipine Besylate-Atorvastatin Calcium Tab 2.5-10 MG
GPI	40992502150310	Amlodipine Besylate-Atorvastatin Calcium Tab 2.5-20 MG
GPI	40992502150315	Amlodipine Besylate-Atorvastatin Calcium Tab 2.5-40 MG
GPI	40992502150320	Amlodipine Besylate-Atorvastatin Calcium Tab 5-10 MG
GPI	40992502150325	Amlodipine Besylate-Atorvastatin Calcium Tab 5-20 MG
GPI	40992502150330	Amlodipine Besylate-Atorvastatin Calcium Tab 5-40 MG
GPI	40992502150335	Amlodipine Besylate-Atorvastatin Calcium Tab 5-80 MG
GPI	40992502150350	Amlodipine Besylate-Atorvastatin Calcium Tab 10-10 MG
GPI	40992502150355	Amlodipine Besylate-Atorvastatin Calcium Tab 10-20 MG
GPI	40992502150360	Amlodipine Besylate-Atorvastatin Calcium Tab 10-40 MG
GPI	40992502150365	Amlodipine Besylate-Atorvastatin Calcium Tab 10-80 MG
GPI	77103010000205	Niacin Cap CR 125 MG
GPI	77103010000210	Niacin Cap CR 250 MG
GPI	77103010000215	Niacin Cap CR 400 MG
GPI	77103010000220	Niacin Cap CR 500 MG
GPI	77103010000320	Niacin Tab 50 MG
GPI	77103010000330	Niacin Tab 100 MG
GPI	77103010000340	Niacin Tab 250 MG
GPI	77103010000350	Niacin Tab 500 MG
GPI	77103010000440	Niacin Tab CR 250 MG
GPI	77103010000450	Niacin Tab CR 500 MG
GPI	77103010000460	Niacin Tab CR 750 MG
GPI	77103010000470	Niacin Tab CR 1000 MG

	GPI 77103010002900 Niacin Powder GPI 77103010002950 Niacin Oral Powder GPI 77103020000310 Niacinamide Tab 100 MG GPI 77103020000315 Niacinamide Tab 500 MG GPI 77103020002900 Niacinamide Powder
6 (2a, 2d)	**Denominator Exclusions:** Hospitalizations **Denominator Exclusion Details** (Definitions, codes with description): Exclude members with inpatient hospitalizations from 0 to 90 days after starting the lipid-lowering medications
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? 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:
10 (2a. 4a, 4b)	**Identify the required data elements**(e.g., primary diagnosis, lab values, vital signs)**:** pharmacy claims, procedures **Data dictionary/code table** attached ☐ see numerator and denominator detail **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: :** 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 (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)*: 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	Measure
17	6,525	0.26%*
7,060	78,311	9.02%
2,200	10,992	20.01%
468	2,035	23.00%
5,513	23,536	23.42%
1,751	7,362	23.78%
46,441	189,135	24.55%
33,310	132,041	25.23%
1,076	3,948	27.25%
949	3,408	27.85%

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

	18,493	63,920	28.93%
	4,514	13,457	33.54%
	1,764	4,545	38.81%
	5,081	12,872	39.47%
	1,067	2,593	41.15%
	5,176	12,577	41.15%
	279	652	42.79%
	1,673	3,750	44.61%

*There appears to have been a data collection issue with this particular group

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: Not applicable

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
- ☐ Meta-analysis
- ☐ Systematic synthesis of research
- ☐ Quantitative research studies
- ☐ Qualitative research studies
- ☒ Other (*Please describe*): Consensus Guideline

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: See question #21 below

[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.

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:** National Heart, Lung, and Blood Institute, National Institutes of Health, US Department of Health and Human Services. Third report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). Bethesda (MD): U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Heart, Lung and Blood Institute; 2001 **Specific guideline recommendation:** After another 6 weeks, the response to therapy should be assessed. If the LDL-cholesterol goal is still not achieved, further intensification of therapy should be considered, with re-evaluation in another 6 weeks. **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)*: The authors did not rate the evidence for this recommendation. A consensus guideline based on expert opinion is typically given a low rating by the USPSTF for estimating certainty of net benefit. **Rationale for using this guideline over others:** This is the authoritative guideline for cholesterol evaluation and treatment.
22 (1c)	**Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.* **Summary:** No significant controversy. **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. **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):** The exclusion is meant to increase specificity. Because inpatient lab tests are commonly rolled-up in summary charges, administrative data do not capture the occurrence of tests like a lipid panel, which could be drawn during the course of hospitalization. Therefore, we excluded patients with hospitalizations within the observation period to increase the specificity of the measure. **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	**Testing comparability of results when more than 1 data method is specified** (*e.g., administrative*

(2g)	*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. **Care Focused Purchasing (CFP)** Care Focused Purchasing, Inc. (CFP) is the largest private or public clinical performance measurement initiative in the nation, representing a coalition of major insurance carriers and more than 50 national self-insured employers. Since CFP's incorporation in 2005, RHI has analyzed medical and pharmacy claims data to assess the quality of care provided by physicians to 29 million CFP employees and 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". Alternatively, to satisfy current NCQA standards, a minimum of 30 observations could be required. 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:** Numerator Denominator Measure 136,832 571,659 23.94%
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: Group Insurance Commission of Massachusetts, Clinical Performance Improvement Initiative; Care Focused Purchasing* *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?** Partially harmonized ►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:*
	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 Constance Hwang – Resolution Health Darren Schulte - Resolution Health Earl Steinberg – 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 Constance Hwang – Resolution Health Darren Schulte - Resolution Health Earl Steinberg – Resolution Health David Gregg – Mercer Russ Robinson - Mercer
46	*Measure Developer/Steward Updates and Ongoing Maintenance* *Year the measure was first released: 2005* *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*)**:** 11/20/2008

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-203-08 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):* 06/25/09
2	*Title of Measure:* Hyperlipidemia (Primary Prevention) - Lifestyle Changes and/or Lipid Lowering Therapy
3	**Brief description of measure [1]:** Percentage of patients with coronary artery disease risk factors who have an elevated LDL and who have initiated therapeutic lifestyle changes or are taking a lipid lowering agent
4 (2a)	**Numerator Statement:** Patients who have initiated therapeutic lifestyle changes or that are taking a lipid lowering agent **Time Window:** A drug day-supply that extends within 30 days of the measurement date **Numerator Details** (Definitions, codes with description): see attached
5 (2a)	**Denominator Statement:** All patients, ages 18 and older, with coronary artery disease risk factors who have an elevated LDL **Time Window:** 12 months **Denominator Details** (Definitions, codes with description): see attached
6 (2a, 2d)	**Denominator Exclusions:** 1. Specific exclusions: • Presence of TSH Labs Result Value > 10 In the past 6 Months • Presence of NEPHROTIC SYNDROME in past 12 months • CAD Validation is confirmed • Diabetes Validation is confirmed • PAD Validation is confirmed • AAA in the past • Carotid endarterectomy in the past General exclusions: • Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months; • Patients who have been in a skilled nursing facility in the last 3 months For add a drug CCs only • Patient or provider feedback indicating allergy or intolerance to the drug in the past

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

	• Patient or provider feedback indicating that there is a contraindication to adding the drug **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:** **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:** **Citations[2] for Evidence:**
18 (1b)	**Opportunity for Improvement** *Provide evidence that demonstrates considerable variation, or overall poor performance, across providers.* **Summary of Evidence:** Audits of cholesterol management in patients with coronary heart disease (CHD) demonstrate that many patients do not achieve targets set out in national guidelines. Under-treatment is a component of the treatment gap and many patients are prescribed low-dose statins. The delivery of systematic care and adoption of more efficacious initial doses will increase the number of patients who achieve recommended low-density lipoprotein cholesterol (LDL-C) levels and maintain their LDL-C goals. Current studies indicate that rosuvastatin, atorvastatin and simvastatin are the most efficacious agents for lowering LDL-C and triglycerides. Compliance and persistence with statin treatment are poor and represent significant barriers to delivering mortality reductions in clinical practice. Efforts to improve concordance are necessary to ensure that treatment benefits are realised in clinical practice. **Citations for Evidence:** British Journal of Cardiology - Statins in Primary Care: Bridging The Treatment Gap
19 (1b)	**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.* **Summary of Evidence:** In men, mean TC increases steadily from early adulthood to middle age and then reaches a plateau, falling only in men older than age 75 years. Mean TC is initially lower in premenopausal women than in men, but it rises at a similar rate. After menopause, however, women experience an additional 10- to 20-mg/dL rise, and their mean TC remains higher than for men throughout the remainder of life. HDL-C levels do not change greatly throughout adulthood and are consistently higher in women than in men (9). Mean TC is similar for those identifying themselves as Caucasian or African American (10). HDL-C is higher for African Americans than for Caucasians **Citations for evidence:** Screening and Treating Adults for Lipid Disorders - Agency for Healthcare Research and Quality
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**

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

	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*)**:** Finally, most persons with 0 to 1 risk factor have a 10-year risk <10%. For these individuals, clinical management and dietary therapy is recommended when the LDL-C level is 160 mg/dL. The goal is to lower LDL-C concentrations to <160 mg/dL. If the LDL-C is 190 mg/dL after an adequate trial of dietary therapy, consideration should be given to adding a cholesterol-lowering drug. When serum LDL-C ranges from 160 to 189 mg/dL, introduction of a cholesterol-lowering drug is a therapeutic option in appropriate circumstances, such as when a severe risk factor is present. ATP III outlines several factors that can be taken into consideration to guide clinical judgment for this category. ATP III placed major emphasis on therapeutic lifestyle changes (TLC) as an essential modality in clinical management for persons at risk for cardiovascular disease (CVD). ATP III's TLC approach was designed to achieve risk reduction through both LDL-C lowering and metabolic syndrome management. Therefore, when the implications of recent LDL-lowering drug trials are considered, it must be reemphasized that the results do not in any way diminish the importance of lifestyle change for CVD risk reduction. **Citations for Evidence:** Executive Summary of the Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) JAMA. 2001;285:2486-2497
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:** ATP III update NCEP Report: Implications of Recent Clinical Trials for the National Cholesterol Education Program Adult Treatment Panel III Guidelines Circulation. 2004;110:227-239.

[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.

	Specific guideline recommendation: According to the ATP III algorithm, persons are categorized into 3 risk categories: (1) established CHD and CHD risk equivalents, (2) multiple (2+) risk factors, and (3) zero to one (0–1) risk factor. CHD risk equivalents include noncoronary forms of clinical atherosclerotic disease, diabetes, and multiple (2+) CHD risk factors with 10-year risk for CHD >20%. All persons with CHD or CHD risk equivalents can be called high risk. The goal for LDL-lowering therapy in high-risk patients is an LDL-C level <100 mg/dL. According to ATP III, for a baseline or on-treatment LDL-C <100 mg/dL, no further LDL-lowering therapy was recommended. For all high-risk patients with LDL-C levels >100 mg/dL, LDL-lowering dietary therapy should be initiated. When baseline LDL-C is >130 mg/dL, an LDL-lowering drug should be started simultaneously with dietary therapy. However, LDL-lowering drugs were not mandated if the baseline LDL-C level is in the range of 100 to 129 mg/dL; in this range, ATP III suggested several therapeutic options. Dietary therapy should be intensified, whereas adding or intensifying an LDL-lowering drug was said to be optional. Alternatively, if the patient has elevated triglycerides or low high-density lipoprotein cholesterol (HDL-C), a drug that targets these abnormalities may be added. **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)*: NA. **Rationale for using this guideline over others:** Nationally recognized guideline
22 (1c)	**Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations*. **Summary:** On the basis of data from multiple clinical trials and 10 years of experience with adverse drug reporting, statins appear to have few important short- or medium-term (initiation to 5 years) adverse effects (17). Myopathy and muscle pain appear to occur infrequently (in about 1 in 500 to 1 in 1000 users). Elevations in liver enzyme levels, which some studies have noted, have not been found in recent large trials and do not seem to produce clinically important consequences. In observational studies, hemorrhagic stroke appears to occur more frequently in patients with low TC levels, but it has not been sufficiently studied in treatment trials to conclude that it is increased in patients who have had their cholesterol levels lowered with statins or other drug therapy. Data from one recent secondary prevention study suggest that, although the incidence of total stroke is decreased by drug therapy, the rate of hemorrhagic stroke may be increased (approximate relative Risk=1.7; 95% CI=0.8 to 3.2) (41). **Citations:** Screening and Treating Adults for Lipid Disorders - Agency for Healthcare Research and Quality
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:** Elevated low-density lipoprotein cholesterol (LDL-C) and low levels of high-density lipoprotein cholesterol (HDL-C) are important risk factors for coronary heart disease (CHD). The increased use of statins in these patients with hyperlipidemia may decrease this risk and reduce subsequent complications and costs.
	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 commercially insured 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 therapeutic lifestyle changes or a lipid lowering agent. 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 38 members who satisfied the denominator, 10 were in the numerator, indicating a compliance rate of 26%.
31	**Identification of Disparities**

(2h)	►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 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; patient derived data. **Methods:** The performance measure is similar in message to a clinical alert that has been operational since 2000. Compliance to the clinical alert is measured using an analysis of subsequent claims, in this case the appearance of pharmacy claims for a statin. 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 23.5% show objective evidence of compliance with the clinical alert.
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:** The computerized data elements and rule algorithms employed by the proposed measure will allow the analysis of large populations to identify individuals appropriate for the measure. Other case-finding methodologies have been limited by the need for chart review and data abstraction.
	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:*

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:* *Generally, the use of claims data has inherent errors and inaccuracies related to incorrect coding, or missing data, which can result in less specificity in the definition of denominator and /or the numerator. To minimize these errors and inaccuracies, we use clinically enriched data (laboratory results, medication lists) to augment the claims data. In addition where possible, to corroborate the claims data, we solicit feedback from both providers via a feedback form and patients from a personal health record or from a disease management program.* *We do not anticipate significant unintended consequences from the implementation of the measure. Our measures are all developed from evidence-based literature or from clinical guidelines and are designed to encourage appropriate care of the patient.* *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 addition 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: 2000* *Month and Year of most recent revision: 06/2009* *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:** This information, including any attachments hereto, is the sole, exclusive, proprietary and confidential property of Active Health Management, Inc., and is for the exclusive use of The National Quality Forum. Any use, copying, disclosure, dissemination or distribution by anyone other than the National Quality Forum is strictly prohibited.
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
Hyperlipidemia (Primary Prevention) - Lifestyle Changes and/or Lipid Lowering Therapy

DENOMINATOR

One of the following is correct:

1. All of the following are correct:

    a. CAD Risk Factor (0-1) validation is confirmed for the member (see below)

    b. One of the following is correct:

        i. Presence of At Least 1 LDL Lab Result Value > 160 in the past 3 months

        ii. Presence of Patient Data Confirming At Least 1 PDD- LDL VALUE > 160 in the past 3 months

2. All of the following are correct:

    a. CAD Risk Factors (2) validation is confirmed for the member (see below)

    b. One of the following is correct:

        i. Presence of At Least 1 LDL Labs Result Value > 130 in the past 3 months

        ii. Presence of Patient Data Confirming At Least 1 PDD- LDL VALUE > 130 in the past 3 months

DENOMINATOR EXCLUSIONS

One of the following is correct:

1. Presence of TSH Labs Result Value > 10 In the past 6 Months
2. Presence of NEPHROTIC SYNDROME in past 12 months

NUMERATOR

All of the following are correct:

1. Denominator is true
2. One of the following is correct:

    a. Presence of a current refill for LIPID LOWERING AGENTS

    b. Presence of patient data confirming at least 1 refill for LIPID LOWERING AGENTS in the past 6 months

c. Presence of patient data confirming PDD- LIPID TREATMENT CHANGE in the past 6 months

---

CAD Risk Factor (0-1) Validation

One of the Following are correct

1. Age >/= 20 Years (and no other risks)
2. Male Age 20-44 or Female Age 20-54 WITH one of the following:
    a) Hypertension Validation is confirmed for the member (see below)
    b) HDL < 40 (Claims or Patient Data) in last 6 months
    c) Patient Data indicating smoking in last 4 weeks
    d) Patient Data indicating family history of premature CAD (first degree male with CAD at age <55, female with CAD at age <65)

Exclusions:

1. CAD Validation is confirmed for the member (see below)
2. Diabetes Validation is confirmed for the member (see below)
3. PAD Validation is confirmed for the member (see below)
4. Presence of At Least 1 AAA REPAIR Procedure In the past
5. Presence of At Least 1 CAROTID ENDARTERECTOMY Procedure In the past

---

Hypertension Adult Validation

All of the following are correct:

1. Patient age >/= 18 years
2. One of the following is correct:
    a. Presence of PDD- HYPERTENSION in the past 24 months
    b. Presence of at least 4 HYPERTENSION diagnosis at least 3 month apart in the past 24 months
    c. All of the following are correct:
        i. Presence of at least 2 HYPERTENSION diagnosis at least 1 month apart in the past 24 months
        ii. One of the following is correct:
            1. Presence of at least 1 refill for ANTIHYPE/ALL in the past 6 months
            2. Presence of patient data confirming at least 1 refill for ANTIHYPE/ALL in the past 6 months

3. Presence of AMBULATORY (24H) BP MONITORING in past 24 months

---

CAD Risk Factors (2) Validation

Two of the following are correct

1. Male Age >= 45 or Female Age >= 55
2. Hypertension Validation is confirmed
3. Presence of At Least 1 HDL Labs Result Value < 40 OR Presence of Patient Data Confirming At Least 1 PDD- HDL VALUE Result < 40 in the past 6 Months
4. Presence of Patient Data Confirming At Least 1 PDD- SMOKER in the past 1 month
5. Presence of Patient Data Confirming At Least 1 PDD- FHx PREMATURE CAD Result Exists in the past

Exclusions:

1. CAD Validation is confirmed for the member (see below)
2. Diabetes Validation is confirmed for the member (see below)
3. PAD Validation is confirmed for the member (see below)
4. Presence of At Least 1 AAA REPAIR Procedure In the past
5. Presence of At Least 1 CAROTID ENDARTERECTOMY Procedure In the past

---

CAD Validation

One of the following is correct:

1. All of the following are correct:
    a. Presence of at least 2 CAD diagnosis anytime in the past
    b. One of the following:
        i. Presence of At Least 1 Refill NITRATES-LONG ACTING in the past 6 months
        ii. Presence of Patient Data Confirming NITRATES-LONG ACTING Drug in the past 6 months
        iii. Presence of At Least 2 Refill NITRATES-SHORT ACTING in the past 6 months
        iv. Presence of At Least 1 Refill ANTIPLATELET AGENTS in the past 6 months
        v. Presence of At Least 1 Refill RANOLAZINE in the past 6 months
2. Presence of at least 1 CABG/PTCA/STENT/THROMBOLYSIS procedure in the past
3. If Myocardial Infarction Validation is Confirmed for the member

4. Patient data confirming at least 1 PDD- CAD/MI/CABG/ANGIOPLASTY in the past

---

Diabetes Adult Validation

All of the following are correct:

1. Patient age ≥18 years
2. One of the following is correct:
    a. Presence of patient data confirming at least 1 PDD- DIABETES in the past 24 months
    b. Presence of at least 4 claims DIABETES MELLITUS diagnosis in the past 12 months with at least a 3 month separation between claims
    c. All of the following are correct:
        i. Presence of at least 1 DIABETES MELLITUS diagnosis in the past 5 years beginning at least 1 month in the past
        ii. One of the following is correct:
            1. Presence of at least 2 refills DM MEDS AND SUPPLIES exists in the past 12 months
            2. Presence of at least 2 DM MEDS AND SUPPLIES (HCPCS) procedure in the past 12 months
            3. Presence of at least 1 INSULIN THERAPY (HCPCS) procedure in the past 12 months
            4. Presence of at least 1 HBA1C VALUE > 7.5 in the past 12 months

Diabetes Validation Exclusion

One of the following is correct:

1. Presence of 2 STEROID-INDUCED DM diagnosis in the past 12 months
2. All of the following are correct:
    - Presence of at least 2 GESTATIONAL DM/POLYCYSTIC OVARIES diagnosis in the past 12 months
    - Female gender

PAD Validation

One of the following is correct:

1. All of the following are correct:
    a. Presence of at least 1 PAD diagnosis in the past
    b. Presence of at least 1 PAD PROCEDURES procedure in the past
2. All of the following are correct:
    a. Presence of at least 2 PAD diagnosis in the past 5 years
    b. One of the following is correct:
        i. Presence of a current refill for PERIPHERAL ARTERIAL DISEASE MEDS
        ii. Presence of at least 1 PAD REHABILITATION procedure in the past
3. Presence of at least 4 PAD diagnosis in the past at least 3 months apart
4. Presence of patient data confirming at least 1 PDD- PERIPHERAL ARTERIAL DISEASE in the past
5. Presence of patient data confirming at least 1 PDD- PAD PROCEDURE in the past
6. Presence of patient data confirming at least 1 PDD- PAD TREATMENT PLAN in the past

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.

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-217-08 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):* 06/25/09
2	*Title of Measure:* Atherosclerotic Disease - Lipid Panel Monitoring
3	**Brief description of measure [1]:** Percentage of patients with coronary artery, cerebrovascular or peripheral vascular disease that have been screened for dyslipidemia with a lipid profile
4 (2a)	**Numerator Statement:** Patients that have claims for a lipid profile **Time Window:** 12 months **Numerator Details** (Definitions, codes with description): see attached
5 (2a)	**Denominator Statement:** All patients > 12 years of age diagnosed with coronary artery disease, cerebrovascular disease or peripheral vascular disease **Time Window:** Anytime in the past **Denominator Details** (Definitions, codes with description): see attached
6 (2a, 2d)	**Denominator Exclusions:** Current refill for a lipid lowering agent, LDL lab result < 100mg/dl (suggests monitoring may be extended to every 24 months) General exclusions: • Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months; • Patients who have been in a skilled nursing facility in the last 3 months **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	**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)

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

(2a, 2e)	► 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)**:** 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)*: 2.1,2.2,6.1
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:** Less than 20 percent of all coronary heart disease patients meet LDL control goals. One in three Americans have some form of cardiovascular disease, which includes coronary heart disease, high blood pressure, heart failure and stroke. Cardiovascular disease causes more deaths every year than cancer, chronic lower respiratory diseases, accidents and diabetes combined, and caused 1 of every 5 deaths in the U.S. in 2004. High cholesterol is a major risk factor for cardiovascular disease, particularly coronary heart disease. Coronary heart disease is the primary cause of heart attacks, and studies have shown cholesterol control to be especially critical after suffering a first heart attack due to the increased risk of a subsequent attack or stroke. Screening and managing cholesterol levels in patients with cardiovascular conditions is very effective at reducing harm caused by coronary heart disease and other cardiovascular disease. HEDIS results from 2007 for cholesterol screening ranges from 75.5% for a MedicAid population to 88% for Medicare and Commercial populations. **Citations for Evidence:** The State of Health Care Quality 2007, available at www.ncqa.org (accessed 10/2008)
19 (1b)	**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.* **Summary of Evidence:** "Disparities in cardiovascular prevention, diagnosis, treatment, and outcomes have been documented in a number of publications from the US Department of Health and Human Services (DHHS), the Institute of Medicine, and the Kaiser Family Foundation, and reports of continuing racial and ethnic disparities appear regularly in cardiovascular scientific journals." "Current data from the Centers for Disease Control and Prevention reported in this issue substantiate the persistent, significantly higher prevalence of risk factors in minority populations, most notable for striking rates of hypertension (41%) in African Americans independent of gender or educational status and obesity (47%) in African American women. High rates of obesity are also reported among Mexican American men and women (33% and 38%, respectively) and among white women with lower levels of education (37%). These risk factor profiles translate into significantly higher rates of stroke in African Americans and heart failure in African Americans, Hispanics, and Native Americans compared with whites. Overall, ischemic heart disease and stroke incidence are inversely related to education and income levels." **Citations for evidence:** Mensah GA, Mokdad AH, Ford ES, Greenlund KJ, Croft JB. State of disparities in cardiovascular health in the United States. Circulation. 2005; 111: 1233–1241.[Robert O. Bonow, Augustus O. Grant, and Alice K. Jacobs. The Cardiovascular State of the Union: Confronting Healthcare Disparities. Circulation 111: 1205-1207, doi:10.1161/01.CIR.0000160705.97642.92 Cooper R, Cutler J, Desvigne-Nickens P, Fortmann SP, Friedman L, Havlik R, Hogelin G, Marler J, McGovern P, Morosco G, Mosca L, Pearson T, Stamler J, Stryer D, Thom T. Trends and disparities in coronary heart

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

	disease, stroke and other cardiovascular diseases in the United States: findings of the National Conference on Cardiovascular Disease Prevention. Circulation. 2000; 102: 3137–3147.
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)*: Evidence for the lipid monitoring recommendation is not specifically graded in the ATP III guidelines; USPSTF grade A would most likely apply, as randomized controlled trials have demonstrated the benefit of lipid management in these patients, although not specifically lipid panel monitoring. **Summary of Evidence** (*provide guideline information below*)**:** The Adult Treatment Panel III (ATP III) of the National Cholesterol Education Program issued an evidence-based set of guidelines on cholesterol management in 2001. Since the publication of ATP III, 5 major clinical trials of statin therapy with clinical end points have been published. These trials addressed issues that were not examined in previous clinical trials of cholesterol-lowering therapy. The present document reviews the results of these recent trials and assesses their implications for cholesterol management. Therapeutic lifestyle changes (TLC) remain an essential modality in clinical management. The trials confirm the benefit of cholesterol-lowering therapy in high-risk patients and support the ATP III treatment goal of low-density lipoprotein cholesterol (LDL-C) _100 mg/dL. They support the inclusion of patients with diabetes in the high-risk category and confirm the benefits of LDL-lowering therapy in these patients. They further confirm that older persons benefit from therapeutic lowering of LDL-C. The major recommendations for modifications to footnote the ATP III treatment algorithm are the following. In high-risk persons, the recommended LDL-C goal is _100 mg/dL, but when risk is very high, an LDL-C goal of _70 mg/dL is a therapeutic option, ie, a reasonable clinical strategy, on the basis of available clinical trial evidence. This therapeutic option extends also to patients at very high risk who have a baseline LDL-C _100 mg/dL. Moreover, when a high-risk patient has high

[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.

	triglycerides or low high-density lipoprotein cholesterol (HDL-C), consideration can be given to combining a fibrate or nicotinic acid with an LDL-lowering drug. For moderately high-risk persons (2_ risk factors and 10-year risk 10% to 20%), the recommended LDL-C goal is _130 mg/dL, but an LDL-C goal _100 mg/dL is a therapeutic option on the basis of recent trial evidence. The latter option extends also to moderately high-risk persons with a baseline LDL-C of 100 to 129 mg/dL. When LDL-lowering drug therapy is employed in high-risk or moderately high-risk persons, it is advised that intensity of therapy be sufficient to achieve at least a 30% to 40% reduction in LDL-C levels. Moreover, any person at high risk or moderately high risk who has lifestyle-related risk factors (eg, obesity, physical inactivity, elevated triglycerides, low HDL-C, or metabolic syndrome) is a candidate for TLC to modify these risk factors regardless of LDL-C level. Finally, for people in lower-risk categories, recent clinical trials do not modify the goals and cutpoints of therapy. **Citations for Evidence:** ATP III Update 2004: Implications of Recent Clinical Trials for the ATP III Guidelines, http://www.nhlbi.nih.gov/guidelines (Accessed November 2008)
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:** NCEP National Cholesterol Education Program Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III); http://www.nhlbi.nih.gov/guidelines 2001 (Accessed April 2006) **Specific guideline recommendation:** 2. Determination and classification of LDL cholesterol a. Who should be tested for cholesterol and lipoproteins? A fasting lipoprotein profile including major blood lipid fractions, i.e., total cholesterol, LDL cholesterol, HDL cholesterol, and triglyceride, should be obtained at least once every 5 years in adults age 20 and over. Since risk categories change slowly over time, the panel judged that lipoprotein measurements once every 5 years are adequate in otherwise low-risk persons. More frequent measurements are required for persons with multiple risk factors or, in those with 0–1 risk factor, if the LDL level is only slightly below the goal level, as will be described subsequently (see Table IV.2–5). **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)***:** Evidence for the lipid monitoring recommendation is not specifically graded in the ATP III guidelines **Rationale for using this guideline over others:** Nationally recognized guideline
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 atherosclerotic disease are at high risk for cardiovascular events. The detection of dyslipidemia allows for early treatment with statins, which may decrease this risk and reduce subsequent complications and costs.
	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 commercially insured 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 a lipid panel. 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 10,041 members who satisfied the denominator, 8,356 were in the numerator, indicating a compliance rate of 83%.
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 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 2001. Compliance to the clinical alert is measured using an analysis of subsequent claims, in this case the appearance of claims for a lipid profile. 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 23.5 % 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):** IVD: Complete Lipid Profile and LDL Control <100D **Are the measure specifications harmonized with existing NQF-endorsed™ measures?** Not harmonized ►If not fully harmonized, provide rationale: The proposed measure has been developed to use clinically enriched claims data; the data elements and rule algorithms are designed to optimize case-finding while maintaining specificity. **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** The computerized data elements and rule algorithms employed by the proposed measure will allow the analysis of large populations to identify individuals appropriate for the measure. Other case-finding methodologies have been limited by the need for chart review and data abstraction.
	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:*
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:* *Generally, the use of claims data has inherent errors and inaccuracies related to incorrect coding, or missing data, which can result in less specificity in the definition of denominator and /or the numerator. To minimize these errors and inaccuracies, we use clinically enriched data (laboratory results, medication lists) to augment the claims data. In addition where possible, to corroborate the claims data, we solicit feedback from both providers via a feedback form and patients from a personal health record or from a disease management program.* *We do not anticipate significant unintended consequences from the implementation of the measure. Our measures are all developed from evidence-based literature or from clinical guidelines and are designed to encourage appropriate care of the patient* *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: 2001* *Month and Year of most recent revision: 06/2009* *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:** This information, including any attachments hereto, is the sole, exclusive, proprietary and confidential property of Active Health Management, Inc., and is for the exclusive use of The National Quality Forum. Any use, copying, disclosure, dissemination or distribution by anyone other than the National Quality Forum is strictly prohibited.
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:
Atherosclerotic Disease - Lipid Panel Monitoring

DENOMINATOR

All of the Following are correct:

1. If Patient Age > 12 Years
2. One of the Following Expressions is correct
    a. If CAD Validation is Confirmed for the member (see below)
    b. If CVA Validation is Confirmed for the member (see below)
    c. If PAD Validation is Confirmed for the member (see below)

DENOMINATOR EXCLUSION

One of the Following is correct

1. Presence of at least 1 LDL Labs Result Value < 100 in the past 24 months

NUMERATOR

All of the Following are correct:

1. Denominator is true
2. If Lipid Panel Monitoring 15 Month is Confirmed for the member (see below)

CAD Validation

One of the following is correct:

1. All of the following are correct:
    a. Presence of at least 2 CAD diagnosis anytime in the past
    b. One of the following:
        i. Presence of At Least 1 Refill NITRATES-LONG ACTING in the past 6 months

ii. Presence of Patient Data Confirming NITRATES-LONG ACTING Drug in the past 6 months

iii. Presence of At Least 2 Refill NITRATES-SHORT ACTING in the past 6 months

iv. Presence of At Least 1 Refill ANTIPLATELET AGENTS in the past 6 months

v. Presence of At Least 1 Refill RANOLAZINE in the past 6 months

2. Presence of at least 1 CABG/PTCA/STENT/THROMBOLYSIS procedure in the past
3. If Myocardial Infarction Validation is Confirmed for the member
4. Patient data confirming at least 1 PDD- CAD/MI/CABG/ANGIOPLASTY in the past

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CVA Validation

All of the following are correct:

1. If patient age >/= 18 years
2. One of the following is correct:
    a. Presence of at least 4 CVA SEQUALE diagnosis at least 1 month apart in the past
    b. Presence of patient data confirming at least 1 PDD- CVA in the past
    c. All of the following are correct:
        i. Presence of at least 2 CVA/TIA diagnosis in the past
        ii. One of the following is correct:
            1. Presence of At Least 1 Refill for AGGRENOX in the past 6 months
            2. Presence of At Least 1 Refill for PLAVIX in the past 6 months
            3. Presence of patient data confirming AGGRENOX in the past 6 months
            4. Presence of patient data confirming PLAVIX in the past 6 months
            5. Presence of at least 1 CAROTID ENDARTERECTOMY procedure in the past

6. Presence of patient data confirming at least 1 PDD- CAROTID ENDARTERECTOMY in the past

7. Presence of At Least 1 CEREBRAL THROMBOLYSIS Procedure in the past

8. Presence of at least 1 HOSPITALIZATION procedure in the past overlapping within 7 days of 1 BRAIN IMAGING procedure and 1 CAROTID DOPPLER procedure in the past

CVA Validation Exclusions:

The following is correct:

Presence of at least 2 INTRACEREBRAL HEMORRHAGE diagnosis in the past

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PAD Validation

One of the following is correct:

1. All of the following are correct:
    a. Presence of at least 1 PAD diagnosis in the past
    b. Presence of at least 1 PAD PROCEDURES procedure in the past
2. All of the following are correct:
    a. Presence of at least 2 PAD diagnosis in the past 5 years
    b. One of the following is correct:
        i. Presence of a current refill for PERIPHERAL ARTERIAL DISEASE MEDS
        ii. Presence of at least 1 PAD REHABILITATION procedure in the past
3. Presence of at least 4 PAD diagnosis in the past at least 3 months apart
4. Presence of patient data confirming at least 1 PDD- PERIPHERAL ARTERIAL DISEASE in the past
5. Presence of patient data confirming at least 1 PDD- PAD PROCEDURE in the past
6. Presence of patient data confirming at least 1 PDD- PAD TREATMENT PLAN in the past

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Lipid Panel Monitoring 15 Months

One of the following is correct:

1. All of the following are correct:
    a. Presence of at least 1 TRIGLYCERIDES VALUE lab result in the past 15 months
    b. Presence of at least 1 HDL VALUE lab result in the past 15 months
    c. Presence of at least 1 CHOLESTEROL TOTAL VALUE labs result in the past 15 months
2. Presence of at least 1 LIPID PANEL (CPT) Procedure In the past 15 months
3. Presence of At Least 1 LIPID PANEL (LOINC) lab result in the past 15 months
4. Presence of patient data confirming LDL 12 MOS OBS in the past 12 months
5. Presence of at least 1 HYPERLIPIDEMIA diagnosis in the past 15 months
6. Presence of patient data confirming PDD- LDL VALUE in the past 12 months
7. All of the following are correct:
    a. Presence of patient data confirming PDD- TOTAL CHOLESTEROL VALUE in the past 12 months
    b. Presence of patient data confirming PDD- HDL VALUE in the past 12 months
    c. Presence of patient data confirming PDD- TRIGLYCERIDE VALUE in the past 12 months
8. Presence of At Least 1 LDL MONITORING lab result in the past 15 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.

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-288-08* 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): 06/25/09*
2	*Title of Measure: Atherosclerotic Disease and LDL Greater than 100 - Use of Lipid Lowering Agent*
3	**Brief description of measure [1]:** Percentage of adult patients with atherosclerotic disease and an LDL greater than 100 that are taking a lipid lowering agent
4 (2a)	**Numerator Statement:** Patients with a current refill for a lipid lowering agent **Time Window:** A drug day-supply that extends within 30 days of the measurement date **Numerator Details** (Definitions, codes with description): see attached
5 (2a)	**Denominator Statement:** All patients diagnosed with atherosclerotic disease and an LDL level above 100 mg/dL **Time Window:** All available historical data for the presence of atherosclerotic disease and 3 months for LDL **Denominator Details** (Definitions, codes with description): see attached
6 (2a, 2d)	**Denominator Exclusions:** 1. Specific exclusions: Presence of Patient Data Confirming provider made a change to their lipid treatment plan in the past 6 month General exclusions: • Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months; • Patients who have been in a skilled nursing facility in the last 3 months • Patient or provider feedback indicating allergy or intolerance to the drug in the past • Patient or provider feedback indicating that there is a contraindication to adding the drug **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):**

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

	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)**:** ICD9, CPT, pharmacy claims, lab values, patient-derived data **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 ☐ Hospice ☐ Hospital ☐ Long term acute care hospital ☒ Nursing home/ Skilled Nursing Facility (SNF) ☐ Prescription Drug Plan ☐ Rehabilitation Facility

	☐ EMS emergency medical services ☐ Substance Use Treatment Program/Center ☒ Health Plan ☐ Other (*Please describe*): ☐ Home Health
	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)*: 2.1,2.2,6.1
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:** Audits of cholesterol management in patients with coronary heart disease (CHD) demonstrate that many patients do not achieve targets set out in national guidelines. Under-treatment is a component of the treatment gap and many patients are prescribed low-dose statins. The delivery of systematic care and adoption of more efficacious initial doses will increase the number of patients who achieve recommended low-density lipoprotein cholesterol (LDL-C) levels and maintain their LDL-C goals. Current studies indicate that rosuvastatin, atorvastatin and simvastatin are the most efficacious agents for lowering LDL-C and triglycerides. Compliance and persistence with statin treatment are poor and represent significant barriers to delivering mortality reductions in clinical practice. Efforts to improve concordance are necessary to ensure that treatment benefits are realised in clinical practice. **Citations for Evidence:** British Journal of Cardiology - Statins in Primary Care: Bridging The Treatment Gap
19 (1b)	**Disparities** *Provide evidence that demonstrates disparity in care/outcomes related to the measure focus among populations.* **Summary of Evidence:** In men, mean TC increases steadily from early adulthood to middle age and then reaches a plateau, falling only in men older than age 75 years. Mean TC is initially lower in premenopausal women than in men, but it rises at a similar rate. After menopause, however, women experience an additional 10- to 20-mg/dL rise, and their mean TC remains higher than for men throughout the remainder of life. HDL-C levels do not change greatly throughout adulthood and are consistently higher in women than in men (9). Mean TC is similar for those identifying themselves as Caucasian or African American (10). HDL-C is higher for African Americans than for Caucasians **Citations for evidence:** Screening and Treating Adults for Lipid Disorders - Agency for Healthcare Research and Quality
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).

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

	• 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*): For lipid management: Assess fasting lipid profile in all patients, and within 24 hours of hospitalization for those with an acute cardiovascular or coronary event. For hospitalized patients, initiate lipid-lowering medication as recommended below before discharge according to the following schedule: ▫LDL-C should be <100 mg/dL I (A), and ▫Further reduction of LDL-C to <70 mg/dL is reasonable. IIa (A) ▫If baseline LDL-C is > 100 mg/dL, initiate LDL-lowering drug therapy.§ I (A) ▫If on-treatment LDL-C is >100 mg/dL, intensify LDL-lowering drug therapy (may require LDL-lowering drug combination_). I (A) ▫If baseline LDL-C is 70 to 100 mg/dL, it is reasonable to treat to LDL-C <70 mg/dL. IIa (B) **Citations for Evidence:** AHA/ACC Guidelines for Secondary Prevention for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2006 Update vol 113
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:** ATP III update NCEP Report: Implications of Recent Clinical Trials for the National Cholesterol Education Program Adult Treatment Panel III Guidelines Circulation. 2004;110:227-239. **Specific guideline recommendation:** According to the ATP III algorithm, persons are categorized into 3 risk categories: (1) established CHD and CHD risk equivalents, (2) multiple (2+) risk factors, and (3) zero to one (0–1) risk factor. CHD risk equivalents include noncoronary forms of clinical atherosclerotic disease, diabetes, and multiple (2+) CHD risk factors with 10-year risk for CHD >20%. All persons with CHD or CHD risk equivalents can be called high risk. The goal for LDL-lowering therapy in high-risk patients is an LDL-C level <100 mg/dL. According to ATP III, for a baseline or on-treatment LDL-C <100 mg/dL, no further LDL-lowering therapy was recommended. For all high-risk patients with LDL-C levels >100 mg/dL, LDL-lowering dietary therapy should be initiated. When baseline LDL-C is >130 mg/dL, an LDL-lowering drug should be started simultaneously with dietary therapy. However, LDL-lowering drugs were not mandated if the baseline LDL-C level is in the range of 100 to 129 mg/dL; in this range, ATP III suggested

[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.

	several therapeutic options. Dietary therapy should be intensified, whereas adding or intensifying an LDL-lowering drug was said to be optional. Alternatively, if the patient has elevated triglycerides or low high-density lipoprotein cholesterol (HDL-C), a drug that targets these abnormalities may be added. **Guideline author's rating of strength of evidence** (*If different from USPSTF, also describe it and how it relates to USPSTF)*: NA **Rationale for using this guideline over others:** Nationally recognized guideline
22 (1c)	**Controversy/Contradictory Evidence** *Summarize any areas of controversy, contradictory evidence, or contradictory guidelines and provide citations.* **Summary:** It had been suggested that there might be a threshold of LDL cholesterol at about 3•2 mmol/L (125 mg/dL), below which lowering it would not reduce risk. By contrast, the present study has demonstrated unequivocally that lowering LDL cholesterol from below 3 mmol/L to below 2 mmol/L (ie, below 116 to below 77 mg/dL) reduces vascular disease risk by about one quarter, which is similar to the proportional reduction in risk produced by a 1 mmol/L reduction at higher LDL cholesterol concentrations. The Adult Treatment Panel (ATP III) of the US National Cholesterol Education Program has recently recommended that the LDL cholesterol concentrations of people considered to be at high risk because of pre-existing coronary disease (or at equivalent coronary risk for other reasons) be reduced to below 2•6 mmol/L (100 mg/dL). In the Heart Protection Study, about 3500 participants presented with a pretreatment LDL cholesterol measurement that was already below this "target" level. Even among them, reducing the average LDL cholesterol during the trial from 2•5 mmol/L (97 mg/dL) in those allocated placebo to 1•7 mmol/L (65 mg/dL) in those allocated simvastatin was safe, and produced a reduction in risk about as great as that seen among those presenting with higher LDL cholesterol concentrations. These findings strongly support the original hypothesis of the study that any thresholds below which lowering LDL cholesterol does not safely reduce risk are at much lower concentrations (eg, below 2 mmol/L [77 mg/dL] of LDL cholesterol or 3•5 mmol/L [135 mg/dL] of total cholesterol) than are typically seen in Western populations. They also indicate that current guidelines may inadvertently lead to substantial under-treatment of high-risk patients who present with LDL cholesterol concentrations below, or close to, particular targets (such as 2•6 mmol/L [100 mg/dL] in the ATP III guidelines,50 or 3•0 mmol/L [116 mg/dL] in the Second European Joint Task Force recommendations51). The Heart Protection Study has, however, shown unequivocally that statin therapy prevents not just coronary events and coronary revascularisations, but also ischaemic strokes and peripheral revascularisations. **Citations:** WMRC/BHF Heart Protection Study of cholesterol lowering with simvastatin in 20,536 high-risk individuals: a randomised placebo controlled trial THE LANCET • Vol 360 • July 6, 2002: 7–22
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 atherosclerotic disease are at high risk for cardiovascular events. The increased use of lipid lowering agents in these patients with hyperlipidemia may decrease this risk and reduce subsequent complications and costs.
	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 commercially insured 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 a lipid lowering agent. 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 35 members who satisfied the denominator, 26 were in the numerator, indicating a compliance rate of 74%.
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 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; patient derived data. **Methods:** The performance measure is similar in message to a clinical alert that has been operational since 2004. Compliance to the clinical alert is measured using an analysis of subsequent claims, in this case the appearance of pharmacy claims for a lipid lowering agent. 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 35.5% show objective evidence of compliance with the clinical alert.
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:** The computerized data elements and rule algorithms employed by the proposed measure will allow the analysis of large populations to identify individuals appropriate for the measure. Other case-finding methodologies have been limited by the need for chart review and data abstraction.
	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:*
37 (4c)	*Do the specified exclusions require additional data sources beyond what is required for the other specifications? No* ►*If yes, provide justification:*
38	*Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure:* *Generally, the use of claims data has inherent errors and inaccuracies related to incorrect coding, or*

(4d)	*missing data, which can result in less specificity in the definition of denominator and /or the numerator. To minimize these errors and inaccuracies, we use clinically enriched data (laboratory results, medication lists) to augment the claims data. In addition where possible, to corroborate the claims data, we solicit feedback from both providers via a feedback form and patients from a personal health record or from a disease management program.* *We do not anticipate significant unintended consequences from the implementation of the measure. Our measures are all developed from evidence-based literature or from clinical guidelines and are designed to encourage appropriate care of the patient.* *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 addition 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: 2001* *Month and Year of most recent revision: 6/2009* *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:** This information, including any attachments hereto, is the sole, exclusive, proprietary and confidential property of Active Health Management, Inc., and is for the exclusive use of The National Quality Forum. Any use, copying, disclosure, dissemination or distribution by anyone other than the National Quality Forum is strictly prohibited.
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:
Atherosclerotic Disease and LDL Greater than 100 - Use of Lipid Lowering Agent

DENOMINATOR

All of the Following are correct:

1. One of the Following is correct:
    i. Presence of AAA REPAIR Procedure in the past
    ii. Presence of CAROTID ENDARTERECTOMY Procedure in the past
    iii. CAD Validation is confirmed for the member (see below)
    iv. PAD Validation is confirmed for the member (see below)

2. One of the Following is correct
    a. Presence of At Least 1 LDL Labs Result Value > 100 in the past 3 months
    b. Presence of Patient Data Confirming At Least 1 PDD- LDL VALUE Result > 100 in the past 3 months

DENOMINATOR EXCLUSION

NUMERATOR

1. All of the Following are correct
    a. Denominator is true
    b. One of the Following is correct
        i. Presence of At Least 1 Current Refill for LIPID LOWERING AGENTS
        ii. Presence of Patient Data Confirming at least 1 LIPID LOWERING AGENTS Drug in the past 6 months
        iii. Presence of Patient Data Confirming At Least 1 PDD- STATIN USE In the past 6 Months

CAD Validation

One of the following is correct:

1. All of the following are correct:
    a. Presence of at least 2 CAD diagnosis anytime in the past
    b. One of the following:
        i. Presence of At Least 1 Refill NITRATES-LONG ACTING in the past 6 months
        ii. Presence of Patient Data Confirming NITRATES-LONG ACTING Drug in the past 6 months
        iii. Presence of At Least 2 Refill NITRATES-SHORT ACTING in the past 6 months
        iv. Presence of At Least 1 Refill ANTIPLATELET AGENTS in the past 6 months
        v. Presence of At Least 1 Refill RANOLAZINE in the past 6 months
2. Presence of at least 1 CABG/PTCA/STENT/THROMBOLYSIS procedure in the past
3. If Myocardial Infarction Validation is Confirmed for the member
4. Patient data confirming at least 1 PDD- CAD/MI/CABG/ANGIOPLASTY in the past

PAD Validation

One of the following is correct:

1. All of the following are correct:
    a. Presence of at least 1 PAD diagnosis in the past
    b. Presence of at least 1 PAD PROCEDURES procedure in the past
2. All of the following are correct:
    a. Presence of at least 2 PAD diagnosis in the past 5 years
    b. One of the following is correct:
        i. Presence of a current refill for PERIPHERAL ARTERIAL DISEASE MEDS
        ii. Presence of at least 1 PAD REHABILITATION procedure in the past

3. Presence of at least 4 PAD diagnosis in the past at least 3 months apart
4. Presence of patient data confirming at least 1 PDD- PERIPHERAL ARTERIAL DISEASE in the past
5. Presence of patient data confirming at least 1 PDD- PAD PROCEDURE in the past
6. Presence of patient data confirming at least 1 PDD- PAD TREATMENT PLAN in the past

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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.