NATIONAL QUALITY FORUM

Measure Evaluation 4.1
December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized)**:** Complete all yellow highlighted areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: *If there is no TAP or workgroup, the SC also evaluates the subcriteria (yellow highlighted areas).*

Steering Committee: Complete all pink highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met
C = Completely (unquestionably demonstrated to meet the criterion)
P = Partially (demonstrated to partially meet the criterion)
M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)
N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) **NQF Review #:** 0018 **NQF Project:** Cardiovascular Endorsement Maintenance 2010
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Controlling High Blood Pressure
De.2 **Brief description of measure**: The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. Use the Hybrid Method for this measure.
1.1-2 **Type of Measure:** Outcome De.3 **If included in a composite or paired with another measure, please identify composite or paired measure**
De.4 **National Priority Partners Priority Area:** Population health De.5 **IOM Quality Domain**: Effectiveness De.6 **Consumer Care Need:** Getting better, Living with illness

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	**NQF Staff**
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. *Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.* A.1 **Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)?** Yes A.2 **Indicate if Proprietary Measure** (*as defined in measure steward agreement*)**:** A.3 **Measure Steward Agreement:** Government entity and in the public domain - no agreement necessary A.4 **Measure Steward Agreement attached:**	**A** **Y☐** **N☐**
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least	**B** **Y☐**

every 3 years. Yes, information provided in contact section	N☐
C. The intended use of the measure includes both public reporting and quality improvement. ►**Purpose:** Public reporting, Internal quality improvement Accountability, Accreditation	C Y☐ N☐
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. D.1**Testing:** Yes, fully developed and tested D.2 **Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?** Yes	D Y☐ N☐
(for NQF staff use) **Have all conditions for consideration been met?** **Staff Notes to Steward** (*if submission returned*)**:**	Met Y☐ N☐
Staff Notes to Reviewers (*issues or questions regarding any criteria*)**:**	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. *Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.* (evaluation criteria) **1a. High Impact**	Eval Rating
(for NQF staff use) **Specific NPP goal**:	
1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, Leading cause of morbidity/mortality, Patient/societal consequences of poor quality **1a.2** **1a.3 Summary of Evidence of High Impact:** Health Importance: Hypertension is a very significant health issue in the United States. Fifty million or more Americans have high blood pressure that warrants treatment, according to the NHANES survey (JNC-7, 2003). The USPSTF recommends that clinicians screen adults aged 18 and older for high blood pressure (USPSTF, 2007). The most frequent and serious complications of uncontrolled hypertension include coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy. The increased risks of hypertension are present in individuals ranging from 40 to 89 years of age. For every 20 mmHg systolic or 10 mmHg diastolic increase in BP, there is a doubling of mortality from both IHD and stroke (JNC-7, 2003). Better control of BP has been shown to significantly reduce the probability that these undesirable and costly outcomes will occur. Thus, the relationship between the measure (control of hypertension) and the long-term clinical outcomes listed is well established. In clinical trials, antihypertensive therapy has been associated with reductions in stroke incidence (35-40%), myocardial infarction (20-25%) and heart failure (>50%) (JNC-7, 2003). The percentage of persons receiving treatment for their hypertension has increased from 31% (1976-1980) to	1a C☐ P☐ M☐ N☐

Comment [KP1]: 1a. The measure focus addresses:
- a specific national health goal/priority identified by NQF's National Priorities Partners; OR
- a demonstrated high impact aspect of healthcare (e.g., affects large numbers, leading cause of morbidity/mortality, high resource use (current and/or future), severity of illness, and patient/societal consequences of poor quality).

59% in 1999-2000. Thirty-four percent of persons with hypertension from 1999-2000 have their blood pressure controlled below 140/90 mmHg compared to 10% from 1976-1980. However, the prevalence and hospitalization rates of heart failure have continued to increase. A majority of the people have hypertension prior to developing heart failure (JNC-7, 2003).

The outcomes that are principally affected by controlling blood pressure are morbidity and mortality related to cerebrovascular and cardiovascular events (e.g., stroke, heart failure and myocardial infarction) (JNC-7, 2003).

In patients ages 65 and older with systolic blood pressure greater than 139, it was estimated that if these persons were in active treatment for their hypertension using antihypertensive drugs alone, the following annual, shot-term benefits would be produced:

- No additional medical costs,
- 115,000 fewer strokes,
- 106,000 fewer CAD events,
- 77,000 fewer deaths,
- 46,000 fewer skilled nursing facility and recovery facility admissions, and
- 4,000 fewer long term care placements (Pyenson, 2004)

The prevalence of high blood pressure by age in Americans 20 and older between 1999 and 2002 was:

- For ages 20-34, 11.1 percent for men and 5.8 percent for women
- For ages 35-44, 21.3 percent for men and 18.1 percent for women
- For ages 45-54, 34.1 percent for men and 34.0 percent for women
- For ages 55-64, 46.6 percent for men and 55.5 percent for women
- For ages 65-74, 60.9 percent for men and 74.0 percent for women
- For ages 75+, 69.2 percent for men and 83.4 percent for women (AHA, 2004)

The death rates per 100,000 in 2002 from high blood pressure were:

- 14.4 for White Males
- 49.6 for Black Males
- 13.7 for White Females
- 40.5 for Black Females (AHA High BP Statistics, 2003)

In the SHEP study involving hypertensive individuals over age 60 with pretreatment SBP >160 and DBP <90 mmHg, individuals treated with chlorthalidone (with or without BB) had reductions in the primary endpoint of stroke (36 percent), as well as HF events (54 percent), MI (27 percent), and overall CVD (32 percent) as compared with the placebo group (SHEP, 1991).

Although no randomized prospective clinical trial has conclusively proven the benefits of treatment of hypertension in individuals with stage 1 systolic hypertension (140–159 mmHg), hypertension therapy should not be withheld in these patients, and therapy should not be withheld on the basis of age (JNC-7, 2003). There is no definitive evidence of an increase in risk of aggressive treatment (a J-curve) unless DBP is lowered to <55 or 60 mmHg by treatment (Somes, 1999).

For treatment of hypertension in patients 80 and older, hypertension is a significant problem. Controlling high blood pressure is important and beneficial for this age group; however there are also significant risks of serious complications and death. In one study, 70% of those 80 and older have hypertension, and among the oldest participants only 38% of men and 23% of women had a blood pressure controlled to less than 140/90 mm Hg. Since the relative and very high absolute risks among those 80 and over are very similar, their data suggest that the 80 and over age group have the most to gain from blood pressure reduction, even if they have a shorter lifespan remaining (Lloyd-Jones, 2005).

A meta-analysis of eight placebo-controlled trials in 15,693 elderly patients followed for 4 years found that active antihypertensive treatment reduced coronary events (23 percent), strokes (30 percent), cardiovascular deaths (18 percent), and total deaths (13 percent), with the benefit particularly great in those older than 70 years (Staessen, 2000). Benefits of therapy have been demonstrated even in individuals over 80 years of age (Hansson, 1999 & Gueyffier, 1999). However, in the same study (Gueyffier, 1999), the meta-analysis showed that while the risk of cardiovascular and stroke events with blood pressure control

decreased, there was an increase in mortality suggesting that a reduction in stroke events of 36% may have to be balanced against a 14% increase in total mortality (Gueyffier, 1999). In addition, a review article by Goodwin showed that BP is protective of mortality in those less than 80 years of age, and that mortality increases with treatment in those older than 80 years of age (Goodwin, 2003).

It is important to exclude patients with End Stage Renal Disease due to the complicated health factors with this condition. Eleven percent of the U.S. population has chronic kidney disease (Smith, 2004). Treatment strategies for hypertension are different for patients with End Stage Renal Disease especially if the patient is on dialysis. Adequacy and duration of dialysis are key determinants of blood pressure in ESRD patients. There seems to be a lack of consensus regarding treatment of hypertension for ESRD patients based on antihypertensive prescription patterns (Griffith, 2003).

Financial Importance:

Hypertension is extremely costly for the United States. High blood pressure and its complications cost the U.S. economy more than $100 billion each year (NHLBI, 2004). When you look at just the office visits to physicians, high blood pressure causes more visits than any other condition. Just a 10% reduction in visits would save $478 million each year (Facts about HBP, NHLBI). To give perspective, in 2002 there were 17.2 million visits to office based physicians related to hypertension (CDC Hypertension Fact Sheet, 2003).

In addition, drugs to treat hypertension are among the leading prescriptions in the U.S.. Two anti-hypertensive drugs are in the NDCHealth Top 50 drugs for 2004 by U.S. sales (NDCHealth Top 200, 2005) and five anti-hypertensive drugs are in the top 11 prescriptions for 2004 by number of U.S. mail and retail prescriptions (NDCHealth Top 10, 2005).

1a.4 **Citations for Evidence of High Impact:** The Seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. (JNC-7) Hypertension. 2003 Dec;42(6):1206-52. Epub 2003 Dec 1.

USPSTF - U.S. Preventive Services Task Force. Screening for high blood pressure: recommendations and rationale. Am J Prev Med. 2003 Aug;25(2):159-64.

Pyenson, et al., Milliman, Inc. "Controlling Hypertension Among Medicare Beneficiaries: Saving Lives Without Additional Cost," (Brookfield, WI: Milliman, 2004). <http://www.phrma.org/publications/policy/23.08.2005.1042.cfm>.AHA.

American Heart Association. High Blood Pressure Statistics. 2004. http://www.americanheart.org/downloadable/heart/1110821765203FS14HBP5.REVdoc.doc Accessed: 8/24/05

AHA. American Heart Association. High Blood Pressure Statistics. 2003. http://www.americanheart.org/presenter.jhtml?identifier=4621 Accessed: 7/18/05

SHEP Cooperative Research Group. Prevention of stroke by antihypertensive drug treatment in older persons with isolated systolic hypertension. Final results of the Systolic Hypertension in the Elderly Program (SHEP). JAMA 1991;265:3255-64.

Somes GW, Pahor M, Shorr RI, Cushman WC, Applegate WB. The role of diastolic blood pressure when treating isolated systolic hypertension. Arch Intern Med 1999;159:2004-9.

Lloyd-Jones DM, Evans JC, Levy D. Hypertension in adults across the age spectrum: current outcomes and control in the community. JAMA 2005; 294(4):466-472.

Staessen JA, Gasowski J, Wang JG, Thijs L, Den Hond E, Boissel JP et al. Risks of untreated and treated isolated systolic hypertension in the elderly: meta-analysis of outcome trials. Lancet 2000; 355(9207):865-872.

Hansson L, Lindholm LH, Ekbom T, Dahlof B, Lanke J, Schersten B et al. Randomised trial of old and new antihypertensive drugs in elderly patients: cardiovascular mortality and morbidity the Swedish Trial in Old

Patients with Hypertension-2 study. Lancet 1999; 354(9192):1751-1756.

Gueyffier F, Bulpitt C, Boissel JP, Schron E, Ekbom T, Fagard R et al. Antihypertensive drugs in very old people: a subgroup meta-analysis of randomised controlled trials. INDANA Group. Lancet 1999; 353(9155):793-796.

Goodwin, James S. Embracing complexity: A consideration of hypertension in the very old. J Gerontol A Biol Sci Med Sci. 2003 Jul;58(7):653-8. Review.

Griffith TF, Chua BS, Allen AS, Klassen PS, Reddan DN, Szczech LA. Characteristics of treated hypertension in incident hemodialysis and peritoneal dialysis patients. Am J Kidney Dis 2003; 42(6):1260-1269.

CDC. National Center for Health Statistics. Hypertension Fact Sheet. 2003. Accessed: 7/14/05. http://www.cdc.gov/nchs/fastats/hyprtens.htm

NDCHealth Top 200 Drugs for 2004 by U.S. Sales. Accessed: 7/25/05. http://www.ndchealth.com/press_center/uspharmaIndustryData/ndchealthtop2002004sales.htm

NDCHealth Top 200 Drugs for 2004 by U.S. Sales Accessed: 7/25/05. http://www.ndchealth.com/press_center/uspharmaindustrydata/2004top10productsbytotalprescription.htm

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: Quality Gap/Room for Improvement

For all product lines, the rates for the measure have been increasing. The national average for 2005 was 66.8% for commercial with a range of 19.2% between the 10th percentile and the 90th percentile, 61.8% for Medicare with a range of 19.3%, and 64.6% for Medicaid with a range of 24.8%.

The mean for commercial plans has increased 8.7% from 2003 to 2005 while the standard deviation has decreased. For Medicare plans, the average rate increase over the past three years was 7.4%, slightly less than commercial plans, and the standard deviation has remained constant. The mean for Medicaid plans has increased 9.5% over the past three years, and the standard deviation has decreased.

Commercial, Medicare and Medicaid rates have increased over the past few years; however rates are still averaging in the low to mid-60%. Certainly the lower performing plans have potential for significant improvement, but even the highest scoring plans could improve considerably.

2006:

Product Line	N	Mean Rate	90th %tile
Commercial ALL	269	68.7	76.3
Commercial HMO	264	68.8	76.3
Commercial PPO	5	60.9	70.6
Medicaid All	92	61.4	71.0
Medicaid HMO	91	61.4	71.0
Medicaid PPO	1	59.9	59.9
Medicare All	161	66.3	75.1
Medicare HMO	159	66.4	75.1
Medicare PPO	2	60.6	65.5

2007:

Product Line	N	Mean Rate	90th %tile
Commercial ALL	261	59.5	68.1
Commercial HMO	257	59.7	68.4
Commercial PPO	4	48.9	67.6
Medicaid All	95	52.9	65.8
Medicaid HMO	94	52.9	65.8
Medicaid PPO	1	51.1	51.1

1b
C☐
P☐
M☐
N☐

Comment [KP2]: 1b. Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating considerable variation, or overall poor performance, in the quality of care across providers and/or population groups (disparities in care).

Medicare All	209	56.8	66.7
Medicare HMO	207	56.8	66.7
Medicare PPO	2	51.2	55.0

2008:

Product Line	N	Mean Rate	90th %tile
Commercial ALL	252	62.2	70.3
Commercial HMO	252	62.2	70.3
Commercial PPO	0	.	.
Medicaid All	114	53.4	65.0
Medicaid HMO	114	53.4	65.0
Medicaid PPO	0	.	.
Medicare All	241	57.6	67.8
Medicare HMO	241	57.6	67.8
Medicare PPO	0	.	.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:

Commercial

Controlling High BP	2003	2004	2005
n	259	277	267
Mean	58.1	62.2	66.8
Standard Deviation	9.7	9.0	7.4
Standard Error	0.6	0.5	0.5
Min	0.0	0.0	41.8
Max	83.1	83.1	83.7
10th Percentile	46.6	51.0	56.2
25th Percentile	53.3	58.6	62.5
50th Percentile	59.4	63.6	67.5
75th Percentile	64.5	67.4	72.3
90th Percentile	68.0	71.2	75.4

Medicare

Controlling High BP	2003	2004	2005
n	151	155	133
Mean	57.0	61.3	64.4
Standard Deviation	7.7	7.9	7.6
Standard Error	0.6	0.6	0.7
Min	32.6	28.5	40.4
Max	75.4	80.3	81.8
10th Percentile	47.0	52.5	54.4
25th Percentile	51.8	57.0	59.9
50th Percentile	58.1	61.8	65.0
75th Percentile	61.9	66.3	69.7
90th Percentile	66.2	69.8	73.7

Medicaid

Controlling High BP	2003	2004	2005
n	77	65	65
Mean	52.3	58.2	61.8
Standard Deviation	11.5	9.2	9.9
Standard Error	1.3	1.1	1.2
Min	15.3	30.0	38.7
Max	71.1	73.9	86.8
10th Percentile	39.4	47.7	48.2
25th Percentile	45.6	52.8	55.8
50th Percentile	54.5	59.9	62.0

Comment [k3]: 1 Examples of data on opportunity for improvement include, but are not limited to: prior studies, epidemiologic data, measure data from pilot testing or implementation. If data are not available, the measure focus is systematically assessed (e.g., expert panel rating) and judged to be a quality problem.

75th Percentile	60.3	65.0	69.0
90th Percentile	64.5	67.6	73.0

1b.3 Citations for data on performance gap:
These results reflect measure performance from our HEDIS and Recognition Programs.

1b.4 Summary of Data on disparities by population group:
None

1b.5 Citations for data on Disparities:
NA

1c. Outcome or Evidence to Support Measure Focus

1c.1 Relationship to Outcomes (*For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population*)**:** The most frequent and serious complications of uncontrolled hypertension include coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy. Better control of BP has been shown to significantly reduce the probability that these undesirable and costly outcomes will occur. Thus, the relationship between the measure (control of hypertension) and the long-term clinical outcomes listed is well established. In clinical trials, antihypertensive therapy has been associated with reductions in stroke incidence (35-40%), myocardial infarction (20-25%) and heart failure (>50%) (JNC-7, 2003).

1c.2-3. Type of Evidence: Evidence-based guideline, Expert opinion, Meta-analysis

1c.4 Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*)**:**
Given the prevalence of hypertension, the impact of uncontrolled hypertension on the population that lead to acute clinical conditions/events, and the cost of care for these conditions, this condition could have a significant impact on health plans. Hypertension is a condition where a proven method for controlling hypertensive patients' blood pressure levels may be high on the list of strategic priorities.

The prevalence of hypertension varies in the population by (JNC-7, 2003):
- Age: prevalence and increased risk is higher in adults 40 to 89 years of age;
- Gender: hypertension is more common among men in early adulthood, however after the age of 50, hypertension in women increases faster than in men, and after the age of 60 the prevalence of hypertension in women is equal to or exceeds that in men;
- Race: blacks are more likely to have hypertension than whites;
- Socioeconomic status: persons with lower incomes and lower educational levels are more likely to have hypertension than those with higher incomes and education levels

While prevalence data are useful for understanding the proportion of persons who have HTN, the question from the perspective of controllability is whether any of these groups represent greater challenges for clinical management. The JNC-7 (2003) indicates that "women are more likely than men to know they have hypertension and to have it treated and controlled. In NHANES III, approximately 75 percent of hypertensive Black and White women were aware of their high BP in contrast to 65 percent of hypertensive men in these ethnic groups. Overall, 61 percent of hypertensive women, but only 44 percent of men were being treated with antihypertensive medications. The higher treatment rates in women have been attributed to increased numbers of physician contact" (JNC-7, 2003).

Health plans can supplement and reinforce patient and provider education related to the importance of blood pressure management in patients with hypertension and the decreased risk of coronary events and death associated with lower levels. Education and communication materials can emphasize the importance of adhering to medication, diet, and weight loss programs. Because response to patient and provider education programs has been mixed, health plans should review interventions conducted by other plans, assess studies on effectiveness and design intervention and patient education programs which have proven effective in like settings.

Hypertension is treatable with lifestyle modifications and if goal is not achieved, antihypertensive drugs can

1c
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N☐

Comment [k4]: 1c. The measure focus is:
•an outcome (e.g., morbidity, mortality, function, health-related quality of life) that is relevant to, or associated with, a national health goal/priority, the condition, population, and/or care being addressed;
OR
•if an intermediate outcome, process, structure, etc., there is **evidence** that supports the specific measure focus as follows:
oIntermediate outcome – evidence that the measured intermediate outcome (e.g., blood pressure, Hba1c) leads to improved health/avoidance of harm or cost/benefit.
oProcess – 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).
oStructure – 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.
oPatient 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.
oAccess – evidence that an association exists between access to a health service and the outcomes of, or experience with, care.
oEfficiency – 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.

Comment [k5]: 4 Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multi-step process, the step with the greatest effect on the desired outcome should be selected as the focus of measurement. For example, although assessment of immunization status and recommending immunization are necessary steps, they are not sufficient to achieve the desired impact on health status – patients must be vaccinated to achieve immunity. This does not preclude consideration of measures of preventive screening interventions where there is a strong link with desired outcomes (e.g., mammography) or measures for multiple care processes that affect a single outcome.

be used. A large number of drugs are currently available for reducing BP. Thiazide-type diuretics should be used as initial therapy for most patients, either alone or in combination with one of the other classes (ACEIs, ARBs, BBs, CCBs) that have also been shown to reduce one or more hypertensive complications in randomized controlled outcome trials (JNC-7, 2004).

1c.5 **Rating of strength/quality of evidence (***also provide narrative description of the rating and by whom***):**

1c.6 **Method for rating evidence:**

1c.7 **Summary of Controversy/Contradictory Evidence:** None

1c.8 **Citations for Evidence (***other than guidelines***):** The Seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. (JNC-7) Hypertension. 2003 Dec;42(6):1206-52. Epub 2003 Dec 1.

Wang Y, Wang QJ. The prevalence of prehypertension and hypertension among US adults according to the new joint national committee guidelines: new challenges of the old problem. Arch Intern Med 2004; 164(19):2126-2134.

1c.9 **Quote the Specific guideline recommendation (***including guideline number and/or page number***):**
1. The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation

2. JNC-7: Treating SBP and DBP to targets that are <140/90 mmHg is associated with a decrease in CVD complications.

1c.10 **Clinical Practice Guideline Citation:** U.S. Preventive Services Task Force. Screening for high blood pressure: U.S. Preventive Services Task Force reaffirmation recommendation statement. Ann Intern Med 2007 Dec 4;147(11):783-6.

Prevention, Detection, Evaluation, and Treatment of High Blood Pressure
The Seventh Report of the Joint National Committee on Prevention,
Detection, Evaluation, and Treatment ofHigh Blood Pressure
NIH P u b l i c a t i o n N o . 0 3 - 5 2 3 3 December 2003

1c.11 **National Guideline Clearinghouse or other URL:**

1c.12 **Rating of strength of recommendation (***also provide narrative description of the rating and by whom***):**
A

1c.13 **Method for rating strength of recommendation** (*If different from USPSTF system, also describe rating and how it relates to USPSTF)***:**

1c.14 **Rationale for using this guideline over others:**

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Importance to Measure and Report?* — **1**

Steering Committee: Was the threshold criterion, *Importance to Measure and Report***, met?** — **1** Y☐ N☐
Rationale:

2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about — **Eval**

Comment [k6]: 3 The strength of the body of evidence for the specific measure focus should be systematically assessed and rated (e.g., USPSTF grading system http://www.ahrq.gov/clinic/uspstf07/methods/benefit.htm). If the USPSTF grading system was not used, the grading system is explained including how it relates to the USPSTF grades or why it does not. However, evidence is not limited to quantitative studies and the best type of evidence depends upon the question being studied (e.g., randomized controlled trials appropriate for studying drug efficacy are not well suited for complex system changes). When qualitative studies are used, appropriate qualitative research criteria are used to judge the strength of the evidence.

Comment [k7]: USPSTF grading system **http://www.ahrq.gov/clinic/uspstf/grades.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.

the quality of care when implemented. (evaluation criteria)	Rating
2a. MEASURE SPECIFICATIONS	
S.1 Do you have a web page where current detailed measure specifications can be obtained? **S.2 If yes, provide web page URL:** **2a. Precisely Specified**	
2a.1 Numerator Statement (*Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome***):** The number of members in the denominator whose most recent BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a member's BP is adequately controlled, the organization must identify the representative BP. **2a.2 Numerator Time Window (***The time period in which cases are eligible for inclusion in the numerator***):** Continuous Enrollment: The measurement year **2a.3 Numerator Details (***All information required to collect/calculate the numerator, including all codes, logic, and definitions***):** Table CBP-A: Codes to Identify Hypertension Description ICD-9-CM Diagnosis Hypertension 401 Table CBP-B: Codes to Identify Outpatient Visits Description CPT Outpatient visits: 99201-99205, 99211-99215, 99241-99245, 99384-99387, 99394-99397	
2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured***):** Event/Diagnosis: Hypertensive. A member is considered hypertensive if there is at least one outpatient encounter (Table CBP-B) with a diagnosis of HTN (Table CBP-A) during the first six months of the measurement year. **2a.5 Target population gender:** **2a.6 Target population age range:** 18-85 years **2a.7 Denominator Time Window (***The time period in which cases are eligible for inclusion in the denominator***):** Continuous Enrollment: The measurement year **2a.8 Denominator Details (***All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions***):** Table CBP-A: Codes to Identify Hypertension Description ICD-9-CM Diagnosis Hypertension 401 Table CBP-B: Codes to Identify Outpatient Visits Description CPT Outpatient visits: 99201-99205, 99211-99215, 99241-99245, 99384-99387, 99394-99397	
2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population***):** • Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (Table CBP-C) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD. • Exclude from the eligible population all members with a diagnosis of pregnancy (Table CBP-C) during the measurement year. • Exclude from the eligible population all members who had an admission to a nonacute inpatient setting any time during the measurement year. Refer to Table FUH-B for codes to identify nonacute care.	**2a-specs** **C☐** **P☐** **M☐** **N☐**

Comment [KP8]: 2a. The measure is well defined and precisely specified so that it can be implemented consistently within and across organizations and allow for comparability. The required data elements are of high quality as defined by NQF's Health Information Technology Expert Panel (HITEP) .

Comment [k9]: 11 Risk factors that influence outcomes should not be specified as exclusions.
12 Patient preference is not a clinical exception to eligibility and can be influenced by provider interventions.

2a.10 Denominator Exclusion Details (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions***):**

Table CBP-C: Codes to Identify Exclusions

Description: Evidence of ESRD	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	UB type of Bill	POS
	36145, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512	G0257, G0308-G0313, G0314-G0319, G0322, G0323, G0326, G0327, G0392, G0393, S9339	585.5, 585.6, V42.0, V45.1, V56	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.6	0367	72X, 080x, 082x, 085x, 088x	65

2a.11 Stratification Details/Variables (*All information required to stratify the measure including the stratification variables, all codes, logic, and definitions***):**

None

2a.12-13 Risk Adjustment Type: No risk adjustment necessary

2a.14 Risk Adjustment Methodology/Variables (*List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method***):**

None.

2a.15-17 Detailed risk model available Web page URL or attachment:

2a.18-19 Type of Score: Rate/proportion

2a.20 Interpretation of Score: Better quality = Higher score

2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps***):**

None

2a.22 Describe the method for discriminating performance *(e.g., significance testing)***:**

After a measure is created, it will go through first-year analysis. This anaysis consists of a review of data completeness, national results, regional results, and eligible population and prevalence. The first-year results are compared by data collection methodology, health plan accreditation status and finally, are compared to the field test results.

2a.23 Sampling (Survey) Methodology *If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)*:

NA

2a.24 Data Source (*Check the source(s) for which the measure is specified and tested)*

Paper medical record/flow-sheet, Electronic administrative data/claims, Electronic clinical data, Electronic Health/Medical Record

2a.25 Data source/data collection instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.***):**

2a.26-28 Data source/data collection instrument reference web page URL or attachment:

2a.29-31 Data dictionary/code table web page URL or attachment:

2a.32-35 Level of Measurement/Analysis (*Check the level(s) for which the measure is specified and tested)*
Clinicians: Individual, Clinicians: Group

2a.36-37 Care Settings (*Check the setting(s) for which the measure is specified and tested)*
Ambulatory Care: Amb Surgery Center, Ambulatory Care: Office, Ambulatory Care: Clinic, Ambulatory Care: Emergency Dept, Ambulatory Care: Hospital Outpatient, All settings

2a.38-41 Clinical Services (*Healthcare services being measured, check all that apply*)
Clinicians: PA/NP/Advanced Practice Nurse, Clinicians: Physicians (MD/DO)

TESTING/ANALYSIS

2b. Reliability testing

2b.1 Data/sample *(description of data/sample and size)*: Product Line Reporting Type Beta binomial Reliability

Commercial	HMO + PPO	0.944903984
Commercial	HMO Only	0.964551482
Commercial	PPO Only	0.963536304
Medicare	HMO + PPO	0.957466173
Medicare	HMO Only	0.968996088
Medicare	PPO Only	0.959233323
Medicaid	HMO Only	0.940821614

2b.2 Analytic Method *(type of reliability & rationale, method for testing)*:
Reliability was estimated by using the beta-binomial model. Beta-binomial is a better fit when estimating the reliability of simple pass/fail rate measures as is the case with most HEDIS measures. The beta-binomial model assumes the plan score is a binomial random variable conditional on the plan´s true value that comes from the beta distribution. The beta distribution is usually defined by two parameters, alpha and beta. Alpha and beta can be thought of as intermediate calculations to get to the needed variance estimates. The beta distribution can be symmetric, skewed or even U-shaped.

Equation for calculating the reliability:
Reliability = Variance (plan-to-plan) / [Variance (plan-to-plan) + Variance (plan-specific-error]

Reliability used here is the ratio of signal to noise. The signal in this case is the proportion of the variability in measured performance that can be explained by real differences in performance. A reliability of zero implies that all the variability in a measure is attributable to measurement error. A reliability of one implies that all the variability is attributable to real differences in performance.

2b
C☐
P☐
M☐
N☐

2b.3 Testing Results *(reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:
NA

2c. Validity testing

2c.1 Data/sample *(description of data/sample and size)*: NA

2c.2 Analytic Method *(type of validity & rationale, method for testing)*:
NA

2c
C☐
P☐
M☐
N☐

2c.3 Testing Results *(statistical results, assessment of adequacy in the context of norms for the test conducted)*:
NA

2d. Exclusions Justified

2d
C☐

Comment [KP10]: 2b. Reliability testing demonstrates the measure results are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period.

Comment [k11]: 8 Examples of reliability testing include, but are not limited to: inter-rater/abstractor or intra-rater/abstractor studies; internal consistency for multi-item scales; test-retest for survey items. Reliability testing may address the data items or final measure score.

Comment [KP12]: 2c. Validity testing demonstrates that the measure reflects the quality of care provided, adequately distinguishing good and poor quality. If face validity is the only validity addressed, it is systematically assessed.

Comment [k13]: 9 Examples of validity testing include, but are not limited to: determining if measure scores adequately distinguish between providers known to have good or poor quality assessed by another valid method; correlation of measure scores with another valid indicator of quality for the specific topic; ability of measure scores to predict scores on some other related valid measure; content validity for multi-item scales/tests. Face validity is a subjective assessment by experts of whether the measure reflects the quality of care (e.g., whether the proportion of patients with BP < 140/90 is a marker of quality). If face validity is the only validity addressed, it is systematically assessed (e.g., ratings by relevant stakeholders) and the measure is judged to represent quality care for the specific topic and that the measure focus is the most important aspect of quality for the specific topic.

Comment [KP14]: 2d. Clinically necessary measure exclusions are identified and must be:
•supported by evidence of sufficient frequency of occurrence so that results are distorted without the exclusion;
AND
•a clinically appropriate exception (e.g., contraindication) to eligibility for the measure focus;
AND
•precisely defined and specified:
–if there is substantial variability in exclusions across providers, the measure is specified so that exclusions are computable and the effect on the measure is transparent (i.e., impact clearly delineated, such as number of cases excluded, exclusion rates by type of exclusion);
if patient preference (e.g., informed decision-making) is a basis for exclusion, there must be evidence that it strongly impacts performance on the measure and the measure must be specified so that the information about patient preference and the effect on the measure is transparent (e.g., numerator category computed separately, denominator exclusion category computed separately).

2d.1 Summary of Evidence supporting exclusion(s):
NA

2d.2 Citations for Evidence:
NA

2d.3 Data/sample *(description of data/sample and size)***:** NA

2d.4 Analytic Method *(type analysis & rationale)***:**
NA

2d.5 Testing Results *(e.g., frequency, variability, sensitivity analyses)***:**
NA

P☐ M☐ N☐ NA☐

Comment [k15]: 10 Examples of evidence that an exclusion distorts measure results include, but are not limited to: frequency of occurrence, sensitivity analyses with and without the exclusion, and variability of exclusions across providers.

2e. Risk Adjustment for Outcomes/ Resource Use Measures

2e.1 Data/sample *(description of data/sample and size)***:** NA

2e.2 Analytic Method *(type of risk adjustment, analysis, & rationale)***:**
NA

2e.3 Testing Results *(risk model performance metrics)***:**
NA

2e.4 If outcome or resource use measure is not risk adjusted, provide rationale: NA

2e
C☐ P☐ M☐ N☐ NA☐

Comment [KP16]: 2e. For outcome measures and other measures (e.g., resource use) when indicated:
•an evidence-based risk-adjustment strategy (e.g., risk models, risk stratification) is specified and is based on patient clinical factors that influence the measured outcome (but not disparities in care) and are present at start of care;[Error! Bookmark not defined.] OR rationale/data support no risk adjustment.

Comment [k17]: 13 Risk models should not obscure disparities in care for populations by including factors that are associated with differences/inequalities in care such as race, socioeconomic status, gender (e.g., poorer treatment outcomes of African American men with prostate cancer, inequalities in treatment for CVD risk factors between men and women). It is preferable to stratify measures by race and socioeconomic status rather than adjusting out differences.

2f. Identification of Meaningful Differences in Performance

2f.1 Data/sample from Testing or Current Use *(description of data/sample and size)***:** NA

2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance *(type of analysis & rationale)***:**
NA

2f.3 Provide Measure Scores from Testing or Current Use *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)***:**
NA

2f
C☐ P☐ M☐ N☐

Comment [KP18]: 2f. Data analysis demonstrates that methods for scoring and analysis of the specified measure allow for identification of statistically significant and practically/clinically meaningful differences in performance.

2g. Comparability of Multiple Data Sources/Methods

2g.1 Data/sample *(description of data/sample and size)***:** NA

2g.2 Analytic Method *(type of analysis & rationale)***:**
NA

2g.3 Testing Results *(e.g., correlation statistics, comparison of rankings)***:**
NA

2g
C☐ P☐ M☐ N☐ NA☐

Comment [k19]: 14 With large enough sample sizes, small differences that are statistically significant may or may not be practically or clinically meaningful. The substantive question may be, for example, whether a statistically significant difference of one percentage point in the percentage of patients who received smoking cessation counseling (e.g., 74% v. 75%) is clinically meaningful; or whether a statistically significant difference of $25 in cost for an episode of care (e.g., $5,000 v. $5,025) is practically meaningful. Measures with overall poor performance may not demonstrate much variability across providers.

2h. Disparities in Care

2h.1 If measure is stratified, provide stratified results *(scores by stratified categories/cohorts)***:** NA

2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:
NA

2h
C☐ P☐ M☐ N☐ NA☐

Comment [KP20]: 2g. If multiple data sources/methods are allowed, there is demonstration they produce comparable results.

Comment [KP21]: 2h. If disparities in care have been identified, measure specifications, scoring, and analysis allow for identification of disparities through stratification of results (e.g., by race, ethnicity, socioeconomic status, gender);OR rationale/data justifies why stratification is not necessary or not feasible.

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Scientific Acceptability of Measure Properties?*

2

Steering Committee: Overall, to what extent was the criterion, *Scientific Acceptability of Measure Properties***, met?**

2
C☐

Rationale:	**P☐ M☐ N☐**
3. USABILITY	
Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)	**Eval Rating**
3a. Meaningful, Understandable, and Useful Information 3a.1 **Current Use:** In use 3a.2 **Use in a public reporting initiative (disclosure of performance results to the public at large)** (*If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years*)**:** Healthcare Effectiveness Data and Information Set (HEDIS) - Health Plans and Physician Measurement 3a.3 **If used in other programs/initiatives (***If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years***):** Quality Compass: http://www.ncqa.org/tabid/177/Default.aspx America´s Best Health Plans: http://www.ncqa.org/tabid/506/Default.aspx **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) 3a.4 **Data/sample** *(description of data/sample and size)***:** None 3a.5 **Methods** *(e.g., focus group, survey, QI project)***:** NA 3a.6 **Results** *(qualitative and/or quantitative results and conclusions)***:** NA	**3a C☐ P☐ M☐ N☐**
3b/3c. Relation to other NQF-endorsed measures 3b.1 **NQF # and Title of similar or related measures:** None	
(for NQF staff use) **Notes on similar/related endorsed or submitted measures:**	
3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source or different topic but same target population): 3b.2 **Are the measure specifications harmonized? If not, why?** Note that this measure is different from the IVD: Blood Pressure Control (0075) measure in that the denominators are different. IVD: Blood Pressure Control (0075) is specific to the population diagnosed with IVD while Contolling High Blood Pressure (0018) measures BP control in the population of patients with a diagnosis of hypertension.	**3b C☐ P☐ M☐ N☐ NA☐**
3c. Distinctive or Additive Value 3c.1 **Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** NA 5.1 **If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality:** NA	**3c C☐ P☐ M☐ N☐ NA☐**
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Usability*?	**3**
Steering Committee: Overall, to what extent was the criterion, *Usability***, met?** **Rationale:**	**3 C☐**

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable

Comment [KP22]: 3a. Demonstration that information produced by the measure is meaningful, understandable, and useful to the intended audience(s) for both public reporting (e.g., focus group, cognitive testing) and informing quality improvement (e.g., quality improvement initiatives). An important outcome that may not have an identified improvement strategy still can be useful for informing quality improvement by identifying the need for and stimulating new approaches to improvement.

Comment [KP23]: 3b. The measure specifications are harmonized with other measures, and are applicable to multiple levels and settings.

Comment [k24]: 16 Measure harmonization refers to the standardization of specifications for similar measures on the same topic (e.g., *influenza immunization* of patients in hospitals or nursing homes), or related measures for the same target population (e.g., eye exam and HbA1c for *patients with diabetes*), or definitions applicable to many measures (e.g., age designation for children) so that they are uniform or compatible, unless differences are dictated by the evidence. The dimensions of harmonization can include numerator, denominator, exclusions, and data source and collection instructions. The extent of harmonization depends on the relationship of the measures, the evidence for the specific measure focus, and differences in data sources.

Comment [KP25]: 3c. Review of existing endorsed measures and measure sets demonstrates that the measure provides a distinctive or additive value to existing NQF-endorsed measures (e.g., provides a more complete picture of quality for a particular condition or aspect of healthcare, is a more valid or efficient way to measure).

	P☐ M☐ N☐
4. FEASIBILITY	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)	Eval Rating
4a. Data Generated as a Byproduct of Care Processes 4a.1-2 **How are the data elements that are needed to compute measure scores generated?** Data generated as byproduct of care processes during care delivery (Data are generated and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition)	4a C☐ P☐ M☐ N☐
4b. Electronic Sources 4b.1 **Are all the data elements available electronically?** (*elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims*) Yes 4b.2 **If not, specify the near-term path to achieve electronic capture by most providers.**	4b C☐ P☐ M☐ N☐
4c. Exclusions 4c.1 **Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications?** 4c.2 **If yes, provide justification.**	4c C☐ P☐ M☐ N☐ NA☐
4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences 4d.1 **Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.** NA	4d C☐ P☐ M☐ N☐
4e. Data Collection Strategy/Implementation 4e.1 **Describe what you have 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:** NA 4e.2 **Costs to implement the measure** (*costs of data collection, fees associated with proprietary measures*)**:** NA 4e.3 **Evidence for costs:** MA 4e.4 **Business case documentation:** NA	4e C☐ P☐ M☐ N☐
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for *Feasibility*?	4
Steering Committee: Overall, to what extent was the criterion, *Feasibility*, **met?** **Rationale:**	4 C☐ P☐ M☐ N☐

Comment [KP26]: 4a. For clinical measures, required data elements are routinely generated concurrent with and as a byproduct of care processes during care delivery. (e.g., BP recorded in the electronic record, not abstracted from the record later by other personnel; patient self-assessment tools, e.g., depression scale; lab values, meds, etc.)

Comment [KP27]: 4b. The required data elements are available in electronic sources. If the required data are not in existing electronic sources, a credible, near-term path to electronic collection by most providers is specified and clinical data elements are specified for transition to the electronic health record.

Comment [KP28]: 4c. Exclusions should not require additional data sources beyond what is required for scoring the measure (e.g., numerator and denominator) unless justified as supporting measure validity.

Comment [KP29]: 4d. Susceptibility to inaccuracies, errors, or unintended consequences and the ability to audit the data items to detect such problems are identified.

Comment [KP30]: 4e. Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, etc.) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use).

RECOMMENDATION	
(for NQF staff use) **Check if measure is untested and only eligible for time-limited endorsement.**	**Time-limited** ☐
Steering Committee: Do you recommend for endorsement? **Comments:**	**Y**☐ **N**☐ **A**☐

CONTACT INFORMATION
Co.1 Measure Steward (Intellectual Property Owner) **Co.1 Organization** National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia, 20005 **Co.2 Point of Contact** Greg, Pawlson, pawlson@ncqa.org, 202-955-5170-
Measure Developer If different from Measure Steward **Co.3 Organization** National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia, 20005 **Co.4 Point of Contact** Greg, Pawlson, pawlson@ncqa.org, 202-955-5170-
Co.5 Submitter If different from Measure Steward POC Greg, Pawlson, pawlson@ncqa.org, 202-955-5170-, National Committee for Quality Assurance
Co.6 Additional organizations that sponsored/participated in measure development

ADDITIONAL INFORMATION
Workgroup/Expert Panel involved in measure development **Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.** NCQA follows a standard process of vetting members of their measurement advisory panels for conflicts of interest.
Ad.2 If adapted, provide name of original measure: NA **Ad.3-5 If adapted, provide original specifications URL or attachment**
Measure Developer/Steward Updates and Ongoing Maintenance **Ad.6 Year the measure was first released:** **Ad.7 Month and Year of most recent revision:** 07, 2009 **Ad.8 What is your frequency for review/update of this measure?** Approximately every 3 years, sooner if the clinical guidelines have changed significantly. **Ad.9 When is the next scheduled review/update for this measure?** 10, 2013
Ad.10 Copyright statement/disclaimers:
Ad.11 -13 Additional Information web page URL or attachment:
Date of Submission (*MM/DD/YY*)**:** 12/31/2010