

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 #: 0075 NQF Project: Cardiovascular Endorsement Maintenance 2010	
MEASURE DESCRIPTIVE INFORMATION	
De.1 Measure Title: IVD: Complete Lipid Profile and LDL Control <100	
De.2 Brief description of measure: The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to measurement year, who had each of the following during the measurement year. <ul style="list-style-type: none"> • Complete Lipid Profile • LDL-C control <100 mg/dL 	
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 These measures are part of the Comprehensive Ischemic Vascular Disease Care measure.	
De.4 National Priority Partners Priority Area: Care coordination, Population health	
De.5 IOM Quality Domain: Effectiveness, Patient-centered	
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. <i>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.</i> 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): Proprietary measure	A Y <input type="checkbox"/> N <input type="checkbox"/>

A.3 Measure Steward Agreement: Agreement will be signed and submitted prior to or at the time of measure submission A.4 Measure Steward Agreement attached:	
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 every 3 years. Yes, information provided in contact section	B Y <input type="checkbox"/> N <input type="checkbox"/>
C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ► Purpose: Public reporting, Internal quality improvement	C Y <input type="checkbox"/> N <input type="checkbox"/>
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 <input type="checkbox"/> N <input type="checkbox"/>
(for NQF staff use) Have all conditions for consideration been met? Staff Notes to Steward (<i>if submission returned</i>):	Met Y <input type="checkbox"/> N <input type="checkbox"/>
Staff Notes to Reviewers (<i>issues or questions regarding any criteria</i>):	
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. <i>Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)</i> 1a. High Impact	Eval Rating
(for NQF staff use) Specific NPP goal :	
1a.1 Demonstrated High Impact Aspect of Healthcare: Leading cause of morbidity/mortality 1a.2 1a.3 Summary of Evidence of High Impact: Health Importance : There is general agreement in the literature that individuals with existing coronary artery disease can reduce their risk of subsequent morbidity and premature mortality by management of cholesterol levels. Total cholesterol in general and LDL level specifically, is the leading indicator for management of these patients. Treatments include limits on dietary fat and cholesterol, or in certain cases, cholesterol lowering medications. BRFSS data from 1991-2003 showed the prevalence of cholesterol screening during the preceding 5 years increased from 67.3% in 1991 to 73.1% in 2003 (CDC, 2005). Between 1988-94 and 1999-2002, the age-adjusted mean total serum cholesterol level of adults age 20 and over decreased from 206 mg/dL to 203 mg/dL and LDL cholesterol levels decreased from 129 mg/dL to 123 mg/dL. The mean level of LDL cholesterol for American adults age 20 and older is 123 mg/dL (Carroll,	1a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>

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).

2005). However, even given this decrease, there is still a significant amount of room for improvement.

A 10% decrease in total cholesterol levels (population wide) may result in an estimated 30% reduction in the incidence of CHD (CDC, 2000). Based on data from the Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults:

- Less than half of persons who qualify for any kind of lipid-modifying treatment for CHD risk reduction are receiving it.
- Less than half of even the highest-risk persons, those who have symptomatic CHD, are receiving lipid-lowering treatment.
- Only about a third of treated patients are achieving their LDL goal; less than 20% of CHD patients are at their LDL goal. (2002)

Several studies have shown that reducing high lipid levels will reduce cardiovascular morbidity and mortality. These studies include the Coronary Primary Prevention Trial, the Framingham Heart Study, the Oslo Study Diet and Anti-smoking Trial, the Helsinki Heart Study, the Coronary Drug Project, the Stockholm Ischemic Heart Study, the Scandinavian Simvastatin Survival Study, the West of Scotland Coronary Prevention Study, the Program on the Surgical Control of the Hyperlipidemias, and Cholesterol and Recurrent Events trial.

The evidence and support of interventions in secondary prevention of coronary artery disease was deemed to be conclusive enough that the American Heart Association and the American College of Cardiology endorsed a consensus statement on the subject (Smith, 1995). Contrary to the prevailing theory that LDL lowering is the link to improved CAD outcomes, there have been some retrospective analyses of angiographic trials which suggest that the best predictors of atherosclerotic progression and regression are baseline triglycerides, intermediate density lipoprotein (IDL), other triglyceride-rich particles, and small, dense LDL (subclass B) (Watts, 1993; Hondis, 1994; Phillips, 1987; Krauss, 1992a; Miller, 1993; Krauss, 1992b; Miller, 1994). The Journal of the American College of Cardiology writes that these analyses cite similar reductions in LDL cholesterol, but point out that the benefits of treatment were often limited to patients with high triglycerides, increased IDL and small, dense LDL. The ACC suggests additional prospective studies are needed to assess the significance of these observations (Forester, 1996).

Financial Importance:

In 2003, the overall cost burden of CVD was estimated at \$351 billion. Of this, \$209 billion made up the amount allocated for healthcare expenditures (direct cost) while \$142 billion was due to lost worker productivity (indirect cost) (CDC). According to the American Heart Association (AHA), the estimate for total cost burden of CVD in 2005 stands at \$393.5 billion, representing a significant increase from 2003 (AHA, 2005).

1a.4 Citations for Evidence of High Impact: AHA/ASA Guidelines for Prevention of Stroke in Patients With Ischemic Stroke or Transient Ischemic Attack A Statement for Healthcare Professionals From the American Heart Association/American Stroke Association Council on Stroke Co-Sponsored by the Council on Cardiovascular Radiology and Intervention. The American Academy of Neurology affirms the value of this guideline. Stroke 2006;37:577-617.

American Heart Association. Heart Disease and Stroke Statistics-2005 Update. Dallas, Texas: American Heart Association; 2005.

Brown BG, Zhao XQ, Sacco DE, Albers JJ. Lipid lowering and plaque regression. New insights into prevention of plaque disruption and clinical events in coronary disease. Circulation 1993, 87:1781-91.

Carroll MD, Lacher DA, Sorlie PD, Cleeman JI, Gordon DJ, Wolz M, Grundy SM, Johnson CL. Trends in serum lipids and lipoproteins of adults. 1960-2002. JAMA. 2005;294:1773-1781.

CDC/NCHS, Vital Health Stat 10. July 2005; No. 225.

Center for Disease Control and Prevention. Preventing Heart Disease and Stroke. Addressing the Nation's Leading Killers. Available at: <http://www.cdc.gov/nccdphp/publications/aag/cvh.htm> Revised August 2005. Accessed March 30, 2006.

Center for Disease Control and Prevention. Preventing Heart Disease and Stroke. Available at: http://www.cdc.gov/nccdphp/bb_heartdisease/. Accessed September 14, 2005.

Centers for Disease Control and Prevention (CDC). State-specific cholesterol screening trends-United States, 1991-1999. *MMWR*. 2000;49:750-755.

Centers for Disease Control and Prevention (CDC). Trends in cholesterol screening and awareness of high blood cholesterol-United States, 1991-2003. *MMWR*. 2005a;54:865- 870.

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;285:2486-97.

Foreester JS, Bairey Merz CN, Bush TL, Cohn JN, Hunninghake DB, Parthasarathy S, Superko HR. Task Force 4. Efficiency of risk factor management. *JACC* 27(5), 1996:964-1047

Grundey SM, Management of high serum cholesterol and related disorders in patients at risk for coronary heart disease. *Am J Med* 1997; 102(2A): 15-22.

Hondis HN, Mack WJ, Azen SP, et al. Triglyceride- and cholesterol-rich lipoproteins have a differential effect on mild/moderate and severe lesion progression as assessed by quantitative coronary angiography in a controlled trial of lovastatin. *Circulation* 1994;90:42-9.

ISIS-2 Collaborative Group. Randomized trial of intravenous streptokinase, oral aspirin, both, or neither among 17,187 cases of suspected myocardial infarction: ISIS-2. (Second International Study of Infarct Survival). *Lancet*. 1988;2:349-360.

Krauss RM, Lindgren FT, Williams PT, et al. Intermediate-density lipoproteins and progression of coronary artery disease with risk factors intervention in patients with LDL subclass pattern B [abstract]. *Circulation* 1992a;86 Suppl 1:I-63.

Krauss RM, Miller BD, Fair JM, Haskell WL, Alderman EL, SCRIP Staff. Reduced progression of coronary artery disease with risk factor intervention in patients with LDL subclass pattern B [abstract]. *Circulation* 1992b;86 Suppl 1:I-63.

Miller BD, Cashin-Hemphill L, Mack WJ, Hodis HN, Krauss RM. Predominance of mid-density low density lipoproteins predicts angiographic benefit of lovastatin in the Monitored Atherosclerosis Regression Study [abstract]. *Circulation* 1994;90 Suppl 1:I-460.

Miller BD, Krauss RM, Cashin-Hemphill L, Blankenhorn DH. Baseline triglyceride levels predict angiographic benefit of cholesterol plus niacin therapy in the Cholesterol-Lowering Atherosclerosis Study (CLAS) [abstract]. *Circulation* 1993;88 Suppl 1:I-363

National Cholesterol Education Program, Second report of the expert panel on Detection, evaluation, and treatment of high blood cholesterol in adults (adult treatment panel II). *Circulation*; 89(3) 1994: 1336-43

Phillips NR, Waters D, Havel RJ. Plasma lipoproteins and progression of coronary artery disease in hypercholesterolaemic men. *Lancet* 1987;62-5.

Phillips NR, Waters D, Havel RJ. Plasma lipoproteins and progression of coronary artery disease in hypercholesterolaemic men. *Lancet* 1987;62-5.

Pignone, M, Earnshaw, S, Tice, JA, and Pletcher, MA. Aspirin, Statins, or Both Drugs for the Primary Prevention of Coronary Heart Disease Events in Men: A Cost-Utility Analysis. *Annals of Internal Medicine*, 2006 144: 326-336.

Preventive Cardiology: how can we do better? Presented at the 33rd Bethesda Conference, Bethesda, MD. December 18, 2001. *J Am Coll Cardiol* 2002;40:579-651.

Probstfield JL. How cost-effective are new preventive strategies for cardiovascular disease? Am J Cardiol. 2003 May 22;91(10A):22G-27G. Review.

Quaglioni S, Cavallini A, Gerzeli S, Micieli G; GLADIS Study Group (Guideline Application for the Decision making in Ischemic Stroke). Economic benefit from clinical practice guideline compliance in stroke patient.

Rashid P, Leonardi-Bee J, Bath P. Blood pressure reduction and secondary prevention of stroke and other vascular events: a systematic review. Stroke. 2003;34:2741-2748.
Respir Care. 2000 Oct;45(10):1200-62. Review.

Roberts LJ, Morrow JD. Analgesic-antipyretic and anti-inflammatory agents and drugs employed in the treatment of gout. In: Hardman JG, ed. Goodman and Gilman's: The Pharmacologic Basics of Therapeutics. New York, NY: McGraw-Hill Companies Inc.; 2001:696-703.

Shaffer J, Wexler LF. Reducing low-density lipoprotein cholesterol levels in an ambulatory care system. Results of a multidisciplinary collaborative practice lipid clinic compared with traditional physician-based care. Arch Intern Med 155(21) 1995:2330-5.

Smith SC, Blair SN, Bonow RO, et al. AHA/ACC guidelines for preventing heart attack and death in patients with atherosclerotic cardiovascular disease: 2001 update: A statement for healthcare professionals from the American Heart Association and the American College of Cardiology. Circulation 2001;104:1577-1579.

Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Pressure. United States, 1997-2001. MMWR. 2005b;54:625- 628.

Watts GF, Mandalia S, Brunt JN, Slavin GM, Coltart DJ, Lewis B. Independent associations between plasma lipoprotein subfraction levels and the course of coronary artery disease in the St. Thomas's Atherosclerosis Regression Study (STARS). Metabolism 1993;42:1461-7.

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: Research has shown individuals with existing coronary artery disease can reduce their risk of subsequent morbidity and premature mortality by managing their cholesterol levels. Studies show that reducing high lipid levels will reduce cardiovascular morbidity and mortality.

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

Data collected from physician applications to the NCOA Heart/Stroke Recognition Program

Comprehensive IVD Care - Complete lipid profile

Year	N Obs	N Obs	Mean	10th	25th	75th	90th
	(Phys.)	(Pts.)					
2005	51	1277	82.98	68.00	76.00	92.00	100.00
2006	561	19053	87.01	72.00	80.00	96.00	100.00
2007	842	23078	85.12	68.57	80.00	96.00	100.00
2008	679	21255	87.24	74.29	80.00	96.00	100.00
2009	208	5386	86.08	72.00	80.00	94.29	97.14

Comprehensive IVD Care - LDL control (<100 mg/dL)

Year	N Obs	N Obs	Mean	10th	25th	75th	90th
	(Phys.)	(Pts.)					
2005	51	1277	62.28	40.00	52.00	72.00	80.00
2006	561	19053	65.25	45.71	52.00	76.00	84.00
2007	842	23078	62.33	44.00	52.00	72.00	82.86
2008	679	21255	65.56	48.00	56.00	76.00	84.00

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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).

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.

2009 208 5386 62.59 45.71 52.00 72.00 80.00

1b.3 Citations for data on performance gap:
NA

1b.4 Summary of Data on disparities by population group:
NA

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): Evidence shows that individuals with existing coronary artery disease can reduce their risk of subsequent morbidity and premature mortality by management of cholesterol levels. A 10% decrease in total cholesterol levels (population wide) may result in an estimated 30% reduction in the incidence of CHD (CDC, 2000). Based on data from the Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults:

- Less than half of persons who qualify for any kind of lipid-modifying treatment for CHD risk reduction are receiving it.
- Less than half of even the highest-risk persons, those who have symptomatic CHD, are receiving lipid-lowering treatment.
- Only about a third of treated patients are achieving their LDL goal; less than 20% of CHD patients are at their LDL goal. (2002)

This measure should improve the number of people who are screened for cholesterol and subsequently receive lipid-lowering therapies.

1c.2-3. Type of Evidence: Evidence-based guideline, Randomized controlled trial

1c.4 Summary of Evidence (as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome):
Controlling high-risk patient's LDL levels has a significant impact on reducing risk of cardiovascular disease and adverse cardiac events. Given the direct impact managing cholesterol in patients with cardiovascular conditions has on clinical outcomes and healthcare costs this measure has significant strategic importance

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:

1c.8 Citations for Evidence (other than guidelines):

1c.9 Quote the Specific guideline recommendation (including guideline number and/or page number):
1. 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). (2001) AND Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidelines (2004)

- In high-risk persons, the recommended LDL-C goal is <100 mg/dL.
- An LDL-C goal of <70 mg/dL is a therapeutic option on the basis of available clinical trial evidence, especially for patients at very high risk.
 - If LDL-C is >100 mg/dL, an LDL-lowering drug is indicated simultaneously with lifestyle changes.
 - If baseline LDL-C is <100 mg/dL, institution of an LDL-lowering drug to achieve an LDL-C level <70

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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. ... [1]

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.

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.

mg/dL is a therapeutic option on the basis of available clinical trial evidence.

- If a high-risk person has high triglycerides or low HDL-C, consideration can be given to combining a fibrate or nicotinic acid with an LDL-lowering drug. When triglycerides are >200 mg/dL, non-HDL-C is a secondary target of therapy, with a goal 30 mg/dL higher than the identified LDL-C goal.

Strength of Evidence: A1 (?)

2. Screening for lipid disorders in adults: U.S. Preventive Services Task Force recommendation statement

Screening Men

The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening men aged 35 and older for lipid disorders. This is a grade A recommendation.

The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease. This is a grade B recommendation.

Screening Women at Increased Risk

The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease. This is a grade A recommendation.

The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease. This is a grade B recommendation.

1c.10 Clinical Practice Guideline Citation: Grundy SM, Cleeman JI, Merz CN, Brewer HB Jr, Clark LT, Hunninghake DB, Pasternak RC, Smith SC Jr, Stone NJ. Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidelines. *Circulation* 2004 Jul 13;110(2):227-39.

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 May. Various p.

U.S. Preventive Services Task Force. Screening for lipid disorders in adults: U.S. Preventive Services Task Force recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2008 Jun. 13

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):

NCEP - A1; USPSTF - B

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

NCEP ATP III

Type of Evidence:

- A. Major randomized controlled trials
- B. Smaller randomized controlled trials and meta-analyses of other clinical trials
- C. Observational and metabolic studies
- D. Clinical experience

Strength of Evidence:

- 1. Very strong evidence
- 2. Moderately strong evidence
- 3. Strong trend

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

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.

Rationale:	Y <input type="checkbox"/> N <input type="checkbox"/>
2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES	
Extent to which the measure, <u>as specified</u> , produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)	Eval 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- specs C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
<p>2a. Precisely Specified</p> <p>2a.1 Numerator Statement (<i>Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome</i>): A complete lipid profile performed during the measurement year. A LDL-C control result of <100mg/dL using the most recent LDL-C screening test during the measurement year.</p> <p>2a.2 Numerator Time Window (<i>The time period in which cases are eligible for inclusion in the numerator</i>): 12 months</p> <p>2a.3 Numerator Details (<i>All information required to collect/calculate the numerator, including all codes, logic, and definitions</i>): Electronic Specification: Complete Lipid Profile: A complete lipid profile performed during the measurement year (table IVD-F) as identified by claim/encounter or electronic laboratory data. LDL-C Control: <100mg/dL Use electronic laboratory data during the measurement year. Calculate a numerator by using the most recent LDL-C screening test. Use the CPT Category II codes in Table CMC-E to determine compliance. The patient is non compliant if: the electronic results for the most recent LDL-C test exceeds the desired threshold, the electronic result for the most recent LDL-C test is missing or an LDL-C test was not done during the measurement year. Medical Record Specification: Complete Lipid Profile: A full lipid profile completed during the measurement year, with the date and result of each component of the profile documented. Identify the most recent visit of the doctor’s office or clinic where a full lipid profile was documented and which occurred during the measurement year (but after the diagnosis of IVD was made). Each component of the lipid profile must be noted with the date of the test and results. LDL Control <100: The number of patients in the denominator whose LDL-C is adequately controlled during the measurement year. Use the most recent LDL-C level performed during the measurement year. At a minimum documentation in the record must include a note indicating the date when the test was performed and the result. Table IVD-F: Codes to Identify a Complete Lipid Profile Description CPT CPT Category II Lipid panel 80061 3011F OR Description CPT LOINC Total cholesterol 82465 2093-3, 14647-2 WITH High density lipoprotein (HDL) 83701 2085-9, 14646-4, 18263-4 AND Triglycerides 84478 2571-8, 12951-0, 14927-8, 47210-0 Table CMC-E: CPT category II codes to identify LDL-C levels LDL-C<100: 3048F LDL-C 100-129: 3049F LDL-C>=130: 3050F</p>	
2a.4 Denominator Statement (<i>Brief, text description of the denominator - target population being</i>	

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) .

measured):

Patients 18 years of age or older as of December 31st of the measurement year who were discharged alive for AMI, CABG or PCI on or between January 1 and November 1 of the year prior to the measurement year or who had a diagnosis of IVD during both the measurement year and the year prior to the measurement year.

2a.5 Target population gender: Female, Male

2a.6 Target population age range: 18 years and older

2a.7 Denominator Time Window (*The time period in which cases are eligible for inclusion in the denominator*):

Between January 1 of the year prior to the measurement year and December 31st of 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*):

Patients 18 years or older as of December 31 of the measurement year who met the following patient inclusion criteria:

For data on physician performance generated from a health plan: Continuous medical benefit enrollment for the measurement year, with no more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, there may not be more than a 1-month gap in coverage during each year of continuous enrollment. The patient must be enrolled as of December 31 of the measurement year.

For data on physician performance generated from non-health plan data: Any enrollment, claim or encounter transaction any time during the measurement year.

Event/ diagnosis: Event. Discharged alive for AMI, CABG or PCI on or between January 1 and November 1 of the year prior to the measurement year. Use the codes listed in Table IVD-A to identify AMI, PCI and CABG. AMI and CABG cases should be from inpatient claims only. All cases of PCI should be included, regardless of setting (e.g., inpatient, outpatient, ED).

Diagnosis. Identify patients as having IVD who met at least one of the two criteria below, during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least one outpatient visit (Table IVD-C) with an IVD diagnosis (Table IVD-B), or
- At least one acute inpatient visit (Table IVD-C) with an IVD diagnosis (Table IVD-B)

Medical record data Documentation of IVD in the medical record includes:

- IVD
- Ischemic heart disease
- Angina
- Coronary atherosclerosis
- Coronary artery occlusion
- Cardiovascular disease
- Occlusion or stenosis of precerebral arteries (including basilar, carotid and vertebral arteries)
- Atherosclerosis of renal artery
- Atherosclerosis of native arteries of the extremities
- Chronic total occlusion of artery of the extremities
- Arterial embolism and thrombosis
- Atheroembolism.

Note: Use paper logs, patient registries or EMRs to identify the denominator, then use the medical record to confirm patient eligibility.

Exclusions None.

Table IVD-A: Codes to Identify AMI, PCI and CABG

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
AMI (inpatient only)			410.x1	
CABG (inpatient only)	36.1, 36.2	33510-33514,	33516-33519,	33521-33523, 33533-33536
				S2205-S2209
PCI	92980, 92982, 92995	G0290		00.66, 36.06, 36.07

Table IVD-B: Codes to Identify IVD

<p>Description ICD-9-CM Diagnosis IVD 411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433, 434, 440.1, 440.2, 440.4, 444, 445 Source: Table CMC-B in Cholesterol Management for Patients With Cardiovascular Conditions.</p> <p>Table IVD-C: Codes to Identify Visit Type Description CPT UB Revenue Outpatient 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456 051x, 0520-0523, 0526-0529, 057x-059x, 0982, 0983 Acute inpatient 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-021x, 072x, 0987</p>
<p>2a.9 Denominator Exclusions (Brief text description of exclusions from the target population): None</p>
<p>2a.10 Denominator Exclusion Details (All information required to collect exclusions to the denominator, including all codes, logic, and definitions): None</p>
<p>2a.11 Stratification Details/Variables (All information required to stratify the measure including the stratification variables, all codes, logic, and definitions): NA</p>
<p>2a.12-13 Risk Adjustment Type: No risk adjustment necessary</p>
<p>2a.14 Risk Adjustment Methodology/Variables (List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method): NA</p>
<p>2a.15-17 Detailed risk model available Web page URL or attachment:</p>
<p>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): NA</p>
<p>2a.22 Describe the method for discriminating performance (e.g., significance testing): After a measure is created, it will go through first-year analysis.</p>
<p>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</p>
<p>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, Lab data</p>
<p>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.): NA</p>
<p>2a.26-28 Data source/data collection instrument reference web page URL or attachment:</p>
<p>2a.29-31 Data dictionary/code table web page URL or attachment:</p>
<p>2a.32-35 Level of Measurement/Analysis (Check the level(s) for which the measure is specified and tested) Clinicians: Individual, Clinicians: Group</p>
<p>2a.36-37 Care Settings (Check the setting(s) for which the measure is specified and tested) Ambulatory Care: Clinic, All settings</p>

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.

<p>2a.38-41 Clinical Services (Healthcare services being measured, check all that apply) Clinicians: PA/NP/Advanced Practice Nurse, Clinicians: Physicians (MD/DO)</p>		
<p>TESTING/ANALYSIS</p>		
<p>2b. Reliability testing</p>		
<p>2b.1 Data/sample (description of data/sample and size): Reliability testing results were generated from NCOA's Heart Stroke Recognition Program (HSRP) data. Complete Lipid Profile N Obs: 2341 N: 2338 LDL<100: 2338 N Obs: 2341 N:</p>		
<p>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. The beta-binomial model assumes the score is a binomial random variable conditional on the 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. 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. The higher the reliability score, the greater is the confidence with which one can distinguish the performance of one entity from another. A reliability score greater than or equal to 0.7 is considered very good.</p>		
<p>2b.3 Testing Results (reliability statistics, assessment of adequacy in the context of norms for the test conducted): Complete Lipid Profile Beta-Binomial Reliability: .73 Coefficient of Variation (CV) (std/mean*100): 13.18 LDL<100 Beta-Binomial Reliability: .69 Coefficient of Variation (CV) (std/mean*100): 22.64</p>	<p>2b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>	
<p>2c. Validity testing</p>		
<p>2c.1 Data/sample (description of data/sample and size): NA</p>		
<p>2c.2 Analytic Method (type of validity & rationale, method for testing): NA</p>	<p>2c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>	
<p>2c.3 Testing Results (statistical results, assessment of adequacy in the context of norms for the test conducted): NA</p>		
<p>2d. Exclusions Justified</p>		
<p>2d.1 Summary of Evidence supporting exclusion(s): NA</p>	<p>2d C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>	
<p>2d.2 Citations for Evidence: NA</p>		
<p>2d.3 Data/sample (description of data/sample and size): NA</p>		

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 ... [2])

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.

<p>2d.4 Analytic Method (type analysis & rationale): NA</p> <p>2d.5 Testing Results (e.g., frequency, variability, sensitivity analyses): NA</p>	
<p>2e. Risk Adjustment for Outcomes/ Resource Use Measures</p> <p>2e.1 Data/sample (description of data/sample and size): NA</p> <p>2e.2 Analytic Method (type of risk adjustment, analysis, & rationale): NA</p> <p>2e.3 Testing Results (risk model performance metrics): NA</p> <p>2e.4 If outcome or resource use measure is not risk adjusted, provide rationale: NA</p>	<p>2e</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>2f. Identification of Meaningful Differences in Performance</p> <p>2f.1 Data/sample from Testing or Current Use (description of data/sample and size): NA</p> <p>2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance (type of analysis & rationale): NA</p> <p>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</p>	<p>2f</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p>2g. Comparability of Multiple Data Sources/Methods</p> <p>2g.1 Data/sample (description of data/sample and size): NA</p> <p>2g.2 Analytic Method (type of analysis & rationale): NA</p> <p>2g.3 Testing Results (e.g., correlation statistics, comparison of rankings): NA</p>	<p>2g</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>2h. Disparities in Care</p> <p>2h.1 If measure is stratified, provide stratified results (scores by stratified categories/cohorts): NA</p> <p>2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans: NCQA has participated with IOM and others in attempting to include information on disparities in measure data collection. However, at the present time, this data, at all levels (claims data, paper chart review, and electronic records), is not coded in a standard manner, and is incompletely captured. There are no consistent standards for what entity (physician, group, plan, employer) should capture and report this data. While "requiring" reporting of the data could push the field forward, it has been our position that doing so would create substantial burden with inability to use the data because of its inconsistency. At the present time, we agree with the IOM report that disparities are best considered by the use of zip code analysis which has limited applicability in most reporting situations. At the health plan level, for HEDIS health plan data collection, NCQA does have extensive data related to our use of stratification by insurance status (Medicare, Medicaid and private-commercial) and would strongly recommend this process where the data base supporting the measurement includes this information. However, we believe that the measure specifications should NOT require this since the measure is still useful where the data needed to determine</p>	<p>2h</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>

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; 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.

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.

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.

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.

disparities cannot be ascertained from the data available.	
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Scientific Acceptability of Measure Properties</i> ?	2
Steering Committee: Overall, to what extent was the criterion, <i>Scientific Acceptability of Measure Properties</i> , met? Rationale:	C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
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). <u>If not publicly reported</u> , state the plans to achieve public reporting within 3 years): Heart Stroke Recognition Program (HSRP)	
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). <u>If not used for QI</u> , state the plans to achieve use for QI within 3 years):	
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 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
3a.6 Results (qualitative and/or quantitative results and conclusions): NA	
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? NCQA is open to harmonizing this measure with other developers' measures; however, the ACC-AHA and MNMCM has established a process for measure development, so no direct harmonization has been performed at this time. NQF is preparing cross walks for both competing measures' evaluation and harmonization. NCQA and AMA PCPI-ACC AHA have initiated discussions regarding harmonizing elements within this measure where there is potential for harmonization. Efforts will continue to determine whether it is possible (and/or alternative strategies) to harmonize denominator conditions (IVD vs. CAD) and the potential risks and benefits to populations being measured. There remain significant differences in the respective measures related to complexity, feasibility, standardization, and medication prescribing.	3b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
3c. Distinctive or Additive Value	
3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures: NA	3c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/>

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).

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	N <input type="checkbox"/> NA <input type="checkbox"/>
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Usability</i> ?	3
Steering Committee: Overall, to what extent was the criterion, <i>Usability</i> , met? Rationale:	3 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
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 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
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)	
4b. Electronic Sources	4b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
4b.1 Are all the data elements available electronically? (<i>elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims</i>) Yes	
4b.2 If not, specify the near-term path to achieve electronic capture by most providers.	
4c. Exclusions	4c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications? No	
4c.2 If yes, provide justification.	
4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences	4d C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
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. None	
4e. Data Collection Strategy/Implementation	4e C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
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 (<i>costs of data collection, fees associated with proprietary measures</i>): NA	
4e.3 Evidence for costs: NA	

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).

4e.4 Business case documentation: NA	
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Feasibility</i> ?	4
Steering Committee: Overall, to what extent was the criterion, <i>Feasibility</i> , met? Rationale:	4 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
RECOMMENDATION	
(for NQF staff use) Check if measure is untested and only eligible for time-limited endorsement.	Time-limited <input type="checkbox"/>
Steering Committee: Do you recommend for endorsement? Comments:	Y <input type="checkbox"/> N <input type="checkbox"/> A <input type="checkbox"/>
CONTACT INFORMATION	
Co.1 Measure Steward (Intellectual Property Owner) Co.1 <u>Organization</u> National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia, 20005	
Co.2 <u>Point of Contact</u> Greg, Pawlson, pawlson@ncqa.org, 202-955-5170-	
Measure Developer If different from Measure Steward Co.3 <u>Organization</u> National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia, 20005	
Co.4 <u>Point of Contact</u> 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 measurement advisory panels for conflicts of interest.	
Ad.2 If adapted, provide name of original measure: 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?	
Ad.10 Copyright statement/disclaimers:	
Ad.11 -13 Additional Information web page URL or attachment:	

Date of Submission (MM/DD/YY): 03/15/2011

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:
 - 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.

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).