NATIONAL QUALITY FORUM

Memo

TO: NQF Members and Public

FR: NQF Staff

RE: Pre-Voting review for: *Gastrointestinal & Genitourinary Endorsement Maintenance: Two-Stage CDP Pilot, Stage 1*

DA: September 26, 2012

NQF has previously endorsed consensus standards to evaluate the quality of care for gastrointestinal (GI) and genitourinary (GU) conditions. This project seeks to endorse measures that can be used for accountability and quality improvement related to GI and GU conditions for adults and children in all settings of care via a two-stage consensus development process. The GI/GU measure endorsement project is a pilot of the proposed two-stage Consensus Development Process (CDP), which is consistent with but not identical to the NQF CDP version 1.9. The pilot began with the evaluation of measure concepts against the importance criteria in stage one. Measures with full specifications and completed testing that pass the importance criterion will be further evaluated against the remaining criteria (scientific acceptability, usability, and feasibility) in stage two scheduled to begin in 2013.

A 15-member Steering Committee representing a range of stakeholder perspectives was appointed to evaluate 18 measures concepts against NQF's Importance to Measure and Report criteria. The Committee recommended the approval of 13 measure concepts.

The draft document, *National Voluntary Consensus Standards: Gastrointestinal & Genitourinary Endorsement Maintenance Two Stage CDP Pilot, Stage 1* is posted on the NQF website along with the concept submission forms.

Pursuant to section II.A of the Consensus Development Process v. 1.9, this draft document, along with the accompanying material, is being provided to you at this time for purposes of review and comment only and is not intended to be used for voting purposes. You may post your comments and view the comments of others on the NQF website. In addition to commenting on the concepts and recommendations of the Committee, we are also seeking comments on the two stage CDP process. If you have comments regarding the process, or specifically the information collected to evaluate the concepts please enter them in the "General Comments".

Please note that the organization of this report has been modified. The intention is to begin with high-level information (e.g., overarching evaluation issues and lists of measures) followed by more detail about the evaluation ratings and rationale in the measure evaluation summary tables. The detailed specifications for the recommended concepts are in Appendix A and all submitted concept information is posted on the project web page.

All comments must be submitted no later than 6:00 pm ET, October 25, 2012.

Thank you for your interest in NQF's work. We look forward to reviewing your comments.

NATIONAL QUALITY FORUM

National Voluntary Consensus Standards: Gastrointestinal and Genitourinary Endorsement Maintenance: Two-Stage Pilot, 2012

STAGE 1 DRAFT TECHNICAL REPORT FOR COMMENT

September 26, 2012

Contents

National Voluntary Consensus Standards: Gastrointestinal and Genitourinary Endorsement Maintenance: Two-Stage Pilot, 2012

STAGE 1 DRAFT TECHNICAL REPORT

Introduction

Gastrointestinal (GI) motility and functional bowel disorders (e.g., gastroesophageal reflux disease, gastroparesis, irritable bowel syndrome), comprise about 40% of the GI problems for which patients seek care and affect up to 25% of the US population.[1] These disorders not only cause symptoms and pose a heavy burden of illness but also impact quality of life and work productivity. With such a high prevalence within the population, the financial burden of the treatment of GI disorders is also high and has been estimated at nearly $10 billion annually in direct costs, and $20 billion annually in indirect costs.[1]

Similarly, genitourinary (GU) conditions, including urinary tract infections (UTI), cystitis, benign prostate hypertrophy (BPH), and urinary incontinence (UI) post a heavy burden on quality of life and healthcare spending:

- In 2000, costs associated with evaluation and treatment of BPH Cost were estimated at $1.1 billion annually[2]
- 8.27 million of the adult outpatient visits in 2000 (1.41 million men; 6.86 million women) were attributed to UTI's as the primary diagnosis with an estimated $3.5 billion expended for evaluation and treatment[2]
- In 2007, UI was estimated to affect 9-22 percent of U.S. adults with an estimated cost of $463.1 million expended annually for evaluation and treatment[2]

NQF has endorsed several consensus standards to evaluate the quality of care for topic areas related to gastrointestinal and genitourinary diseases over the last several years. As quality measurement has matured, better data systems have become available, electronic health records are closer to widespread adoption, and the demand for meaningful performance measures has prompted development of more sophisticated measures of healthcare processes and outcomes for gastrointestinal and genitourinary conditions. An evaluation of the NQF-endorsed® gastrointestinal and genitourinary measures and consideration of new measures will ensure the currency of NQF's portfolio of voluntary consensus standards.

1.Camilleri M, Dubois D, Coulie B, et al. Prevalence and socioeconomic impact of upper gastrointestinal disorders in the United States: results of the US Upper Gastrointestinal Study. Clin Gastroenterol Hepatol,2005;3(6):543-552.
2. Litwin MS, Saigal CS. Introduction. In: Litwin MS, Saigal CS, eds. Urologic Diseases in America. Washington, D.C.: Government Printing Office; 2007; NIH publication 07–5512:3–7. Available at http://kidney.niddk.nih.gov/statistics/uda/UDA_Introduction.pdf. Last accessed May 2012.

Concept Evaluation

On August 27-28, 2012 the GI/GU Steering Committee evaluated 18 measure concepts, both new and maintenance. Thirteen measure concepts were recommended for approval. This GI/GU measure endorsement project is a pilot of the proposed two-stage Consensus Development Process (CDP), which is consistent with but not identical to the NQF CDP version 1.9. The pilot began with the evaluation of concepts and measures against the importance criterion in stage one, including measures that are submitted with full specifications and testing and those undergoing maintenance. This project also piloted new a new pre-meeting member comment period in stage one. The two week comment period was open to NQF members to submit comments for consideration and discussion by the Committee at the in person meeting. Measures with full specifications and completed testing that pass the importance criterion will be further evaluated against the remaining criteria (scientific acceptability, usability, and feasibility) in stage two scheduled to begin in 2013. The Committee's discussion and ratings of the criteria are summarized in the evaluation tables beginning on page 7.

GI/GU ENDORSEMENT MAINTENANCE, 2012 SUMMARY

	MAINTENANCE	NEW	TOTAL
Concepts under consideration	6	12	18
Concepts Recommended for Approval	6	7	13
Concepts Not recommended for Approval	0	5	5

Overarching Issues

Evidence guidance

Many of the measure submissions to this project did not include sufficient information on the quantity, quantity and consistency of the evidence supporting the measure focus. For example, referring to guidelines without the description of the underlying studies that support the guidelines made it difficult for the Committee to rate the evidence subcriterion as described by the NQF 2010 Evidence Task Force report. In July 2012, the Consensus Standards Approval Committee (CSAC) discussed the challenges of the information required for the evidence subcriterion identified by NQF staff and measure developers. The CSAC decided that despite the heterogeneous state of guideline development, specifically the transparency of the evidence supporting guidelines, there is no need to change the criterion and every effort should be made by the developers to provide the information needed by the Committee to evaluate the evidence subcriterion. If required, the experts on the Committee can supplement their knowledge of the evidence; however, it should be made clear when there is a lack of evidence cited by the developer to support the measure focus.

The information provided to the Committee for the GI/GU measures was quite variable in detail and responsiveness to the NQF criterion for the quantity, quality and consistency of the evidence. To provide greater transparency in the Committee voting "NO" for the evidence criterion, two "NO" voting options were given:

1. No, evidence does not meet guidance for quantity, quality, consistency (including no empirical evidence exists)

   If the Committee voted *No, evidence does not meet guidance for quantity, quality, consistency (including no empirical evidence exists)* they were given an opportunity to invoke an exception to the evidence criterion by weighing the benefits and harms to using the measure despite the lack of specific evidence. If the Committee agreed, based on a majority vote, that the benefits outweighed the harms, the concept would continue in the evaluation process.

2. No, insufficient information submitted to rate quantity, quality, consistency of body of evidence.

   If the Committee voted *No, insufficient information submitted to rate quantity, quality, consistency of body of evidence,* they were given an opportunity discuss the body of evidence available based on their expert knowledge. If in the Committee's expert opinion the body of evidence would meet the NQF's criteria for quantity, quality, and consistency, the concept could continue in the evaluation process based on a majority vote.

Concept Evaluation Summary

GU Concepts Recommended for Approval

GI Concepts Recommended for Approval

GU Concepts Not Recommended for Approval

GI Concepts Not Recommended for Approval

GU Concepts Recommended for Approval

0030 Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure

Measure Concept Submission Form

Status: Maintenance, Original Endorsement: August 10, 2009

Description: This is a patient-reported measure collected through the Health Outcomes Survey with two rates that address management of urinary incontinence in older adults.

Discussing urinary incontinence: Percentage of patients 65 years of age and older who self-report having a urine leakage problem in the last six months and who discussed their urinary leakage problem with their health care provider.

Receiving urinary incontinence treatment: The percentage of patients 65 years of age and older who self-report having a urine leakage problem in the last six months and who received treatment for their current urine leakage problem.

Numerator Statement: a) Discussing Urinary Incontinence: The number of patients who reported having a problem with urine leakage in the past 6 months and indicated they discussed their urine leakage problem with their current provider.

b) Receiving Urinary Incontinence Treatment: The number of patients who reported having a problem with urine leakage in the past 6 months and indicated they received treatment for their current urine leakage problem.

Denominator Statement: The number of patients 65 years and older who responded to the survey indicating they had accidentally leaked urine in the past 6 months and their urine leakage was a problem.

Exclusions: N/A

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Health Plan, Integrated Delivery System

Type of Measure: Process

Data Source: Patient Reported Data/Survey

Measure Steward: National Committee for Quality Assurance

MEMBER COMMENTS (August 7-21, 2012)

None

STEERING COMMITTEE MEETING (August 27-28, 2012)

1. Importance to Measure and Report:

1a. High Impact: **H-14; M-0; L-0; I-0**

Discussion: General agreement that incontinence addresses a high impact area. This is a bothersome issue that occurs in a high percentage of women.

1c. Evidence:

15: Yes, body of evidence meets guidance for quantity, quality, consistency

Discussion:

- The developer's review of the evidence did not specify how many RCTs were completed in the review of quantity of evidence.
- There was agreement among the GU experts that the evidence to support the guidelines (ACOG, SIGN) was sufficient to support this measure focus.

0: No, body of evidence does not meet guidance for quantity, quality, consistency

0030 Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure

0: No, inadequate information to rate quantity, quality, consistency of body of evidence

1b. Performance Gap: **H-13; M-2; L-0; I-0**

Discussion: Based on the data provided for this maintenance measure, the Committee agrees there is still a performance gap and an opportunity for improvement.

Recommendations to Developer for Stage 2:

- Consider adjusting the numerator to also include patients who were offered treatment, but refused. Currently, the numerator specifies that the patient had to receive treatment. Because treatment is a patient choice, not receiving treatment may not actually represent poor quality.
  - **Developer Response**: NCQA is working on a modified version of this measure. In about a year when testing is completed, this concern will be addressed in the updated measure. Because this measure is based on an established survey with specific questions, it is not easy to change.
- Update submission form to clarify the number (quantity) of studies, particularly RCT's that support the measure focus.
- Expand age group to include commercial and menopausal population.

Steering Committee Recommendation for Approval of Concept: Y-15; N- 0

0098 Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure

Measure Concept Submission Form

Status: Maintenance, Original Endorsement: May 1, 2007

Description: This is a clinical performance measure which assesses whether women age 65+ were provided appropriate treatment for urinary incontinence (UI). This measure has three rates:

(A) Assessment for UI: Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.

(B) Characterization of UI: Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months

(C) Plan of Care for UI: Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months

Numerator Statement: This measure has three rates. The numerator for each of the rates is as follows:

(A) Assessment for UI: Patients who were assessed for the presence or absence of urinary incontinence within 12 months

(B) Characterization of UI: Patients whose urinary incontinence was characterized at least once within 12 months

(C) Plan of Care for UI: Patients with a documented plan of care for urinary incontinence at least once within 12 months

Urinary incontinence is defined as any involuntary leakage of urine.

Characterization of urinary incontinence may include one or more the following: frequency, volume,

timing, type of symptoms, and/or how bothersome to the patient

Plan of care may include behavioral interventions (e.g., bladder training, pelvic floor muscle training, prompted voiding), referral to specialist, surgical treatment, reassess at follow-up visit, lifestyle interventions, addressing co-morbid factors, modification or discontinuation of medications contributing to urinary incontinence, or pharmacologic therapy.

Denominator Statement: There are two denominators for the rates in this measure.

(A) Assessment of UI: All female patients aged 65 years and older who visited and eligible provider in the measurement year

(B&C) Characterization and Plan of Care for UI: All female patients aged 65 years and older with a diagnosis of urinary incontinence who visited an eligible provider in the measurement year.

Exclusions: Documentation of medical reason(s) for not assessing the presence or absence of urinary incontinence within 12 months

Adjustment/Stratification: No risk adjustment or risk stratification N/A

Level of Analysis: Clinician Group/Practice, Individual Clinician/Team

Type of Measure: Process

Data Source: Administrative claims

Measure Steward: National Committee for Quality Assurance

MEMBER COMMENTS (August 7-21, 2012)

None

STEERING COMMITTEE MEETING (August 27-28, 2012)

1. Importance to Measure and Report:

1a. High Impact: **H-15; M-0; L-0; I-0**

Discussion: Similar impact as discussed in #0030. General agreement that incontinence is a high impact area.

1c. Evidence

13: Yes, body of evidence meets guidance for quantity, quality, consistency

Discussion: The Committee agreed that this measure was similar to NQF #0030; however, this measure is based on administrative claims and provides a different perspective than NQF #0030, which is based on patient report. The Committee was concerned that the evidence presented by the developer indicated that incontinence should be treated but did not provide evidence that documentation in the medical record improved incontinence. Some expressed concern about the link between this process measure and patient outcomes. However, the Committee ultimately agreed this measure meets the evidence criteria since existing literature does link discussion with the provider about urinary incontinence to improved outcomes.

0: No, body of evidence does not meet guidance for quantity, quality, consistency

2: No, inadequate information to rate quantity, quality, consistency of body of evidence

1b. Performance Gap: **H-7; M-8; L-0; I-0**

Discussion:

- While PQRS data does not show a performance gap, the Committee agreed that there is overall

0098 Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure
low performance and low reporting based on the data submitted.
Recommendations to Developer for Stage 2: • eMeasure specifications are strongly recommended. • Consider the addition of an option for patient choice of no treatment. • Expand age group to include commercial and menopausal population.
Steering Committee Recommendation for Approval of Concept: Y-14; N- 1

C 2038 Performing vaginal apical suspension (uterosacral, iliococygeus, sacrospinous or sacral colpopexy) at the time of hysterectomy to address uterovaginal prolapse
Measure Concept Submission Form **Description:** Percentage of female patients undergoing hysterectomy for the indication of uterovaginal prolapse in which a concomitant vaginal apical suspension (i.e.uterosacral, iliococygeus, sacrospinous or sacral colpopexy) is performed. **Numerator Statement:** The number of female patients who have a concomitant vaginal apical suspension (i.e. uterosacral, iliococygeus, sacrospinous or sacral colpopexy) at the time of hysterectomy for uterovaginal prolapse. **Denominator Statement:** Hysterectomy, performed for the indication of uterovaginal prolapse **Exclusions:** • Patients with a gynecologic or other pelvic malignancy noted at the time of hysterectomy • Patients undergoing a concurrent obliterative procedure (vaginectomy) • Patients undergoing excision of prolapsed cervix only (prior sub-total hysterectomy) **Adjustment/Stratification:** No, we do not plan to risk adjust the measure. No, we do not plan to stratify the measure results. **Level of Analysis:** Clinician Group/Practice, Individual Clinician **Type of Measure:** Process **Data Source:** Administrative claims, Paper Medical Records **Measure Steward:** American Urogynecologic Society
MEMBER COMMENT (August 7-21, 2012)
None
STEERING COMMITTEE MEETING (August 27-28, 2012)
1. Importance to Measure and Report: **1a.** High Impact: **H-13; M-1; L-0; I-0** **Discussion:** There was general agreement this measure focus is high impact as prolapse repair is a common procedure performed 100,000 to 200,000 per year. In addition to impacting a large number of individuals, the cost of treatment and rate of complications are high. **1c.** Evidence

C 2038 Performing vaginal apical suspension (uterosacral, iliococygeus, sacrospinous or sacral colpopexy) at the time of hysterectomy to address uterovaginal prolapse
14: Yes, body of evidence meets guidance for quantity, quality, consistency **Discussion:** The Committee agreed that there is good evidence supporting the measure focus in terms of published systematic reviews, including randomized controlled trials. The Committee also agreed that there is a clear link between this process and outcomes that are important to patients. **0**: No, body of evidence does not meet guidance for quantity, quality, consistency **0**: No, inadequate information to rate quantity, quality, consistency of body of evidence **1b.** Performance Gap: **H-12; M-1; L-0; I-1** **Discussion:** Based on the data provided for this concept, the Committee agrees there is a performance gap and an opportunity for improvement.
Recommendations to Developer for Stage 2: None
Steering Committee Recommendation for Approval of Concept: Y-14; N- 0

C 2049 Complete Workup for Assessment of Stress Urinary Incontinence (SUI) Prior to Surgery
Measure Concept Submission Form **Status:** New Submission **Description:** Percentage of female patients who had SUI surgery and who received a complete workup assessing stress urinary incontinence and for whom SUI is objectively demonstrated within 12 months prior to surgery **Numerator Statement:** Female patients who received the following as part of their complete workup within 12 months prior to surgery: Characterization of incontinence: focused history (questions asked of patient: duration of incontinence; number of episodes; use of protective products; i.e. "bother") focused physical exam; objective demonstration of stress incontinence; post void residual analysis; urinary analysis and urine culture, if indicated **Denominator Statement:** All female patients who had SUI surgery without concomitant surgery for prolapse. Patients with concomitant surgery for prolapse were excluded from the denominator because these measures are based on the AUA SUI guidelines which focused on an index patient without concomitant prolapse surgery. Prolapse surgery patients complicate the interpretation of the quality measures for SUI surgery such as characterization of prolapse symptoms, documentation of the involved compartments, and the severity of prolapse of each of the compartments as part of the physical exam. These elements are not necessary for stress incontinence patients. Prolapse patients should be excluded prior to SUI surgery to avoid potential complications. **Exclusions:** Documentation of medical reason(s) for not performing a complete workup for assessment of stress urinary incontinence (such as prolapse; cognitive impairment limiting characterization of SUI--information might be obtained via caregiver). **Adjustment/Stratification:** **Level of Analysis:** Individual Clinician **Type of Measure:** Process

C 2049 Complete Workup for Assessment of Stress Urinary Incontinence (SUI) Prior to Surgery

Data Source: Administrative claims, Paper Medical Records
Measure Steward: American Urological Association

MEMBER COMMENTS (August 7-21, 2012)

America's Health Insurance Plans - This measure is not easily collected through administrative data and will require burdensome chart abstraction.

STEERING COMMITTEE MEETING (August 27-28, 2012)

1. Importance to Measure and Report:

1a. High Impact: **H-13; M-2; L-0; I-0**

Discussion: There is general agreement this measure focus addresses a high impact area.

1c. Evidence

0: Yes, body of evidence meets guidance for quantity, quality, consistency
4: No, body of evidence does not meet guidance for quantity, quality, consistency

Discussion:

- There are a few studies to support this measure focus. There will not likely be a randomized control trial to support this assessment measure as it is already accepted as a standard of care based on consensus.
- There is no empirical evidence to support the measure focus.

11: No, inadequate information to rate quantity, quality, consistency of body of evidence

Discussion:

- There were a couple studies identified by a Committee member, not cited by the developer, which support the use of pre-surgical assessments and linked to surgical outcomes.
- *There an exceptional and compelling reason that the measure should be considered further (i.e., benefits outweigh the harms):* **Y-15; N- 0**

  Discussion:

  - The Committee ultimately agreed that there is insufficient evidence to support the measure focus but the benefits clearly outweigh the harms so agreed that the evidence subcriterion was met.

1b. Performance Gap: **H-0; M-13; L-2; I-0**

Discussion:

- The data submitted for the performance gap was not directly related to the five items specified in the numerator.
- The Committee agreed these items are standards of care and questioned whether it warrants a national consensus standard with this focus. The Committee ultimately agreed there is sufficient data to support a performance gap.

Recommendations to Developer for Stage 2:

- Reconsider the exclusions specified in this concept: excluding people for medical reasons or for cognitive impairment are not reasons for not having a work up.

C 2049 Complete Workup for Assessment of Stress Urinary Incontinence (SUI) Prior to Surgery
• Combine with C 2050 to include both components of care in the numerator for the same population in the denominator.
Steering Committee Recommendation for Approval of Concept: Y-15; N- 0 **Discussion**: While the Committee struggled to discern the link between completing an assessment and performing the appropriate surgery or better outcomes, they did agree that an assessment to determine the type of incontinence is important to selecting the right type of surgery for a patient. This concept was recommended for approval.

C 2050 Patient counseling on treatment options, including behavioral and surgical treatments prior to Stress Urinary Incontinence (SUI) surgery
Measure Concept Submission Form **Status:** New Submission **Description:** Percentage of female patients who had SUI surgery for whom there was documentation that treatment options were discussed with the patient, including behavioral and surgical treatments, and expectations for treatment (discuss cure/dry rates) **Numerator Statement:** Female patients who had SUI surgery for whom there was documentation that treatment options were discussed with the patient, including behavioral and surgical, and expectations for treatment (discuss cure/dry rates) **Denominator Statement:** Female patients who had SUI surgery (without concomitant surgery for prolapse) **Exclusions:** Documentation of medical reason(s) for not counseling patient (e.g. patients who had concomitant prolapse or who are severely cognitively impaired). Documentation of patient reason(s) for not counseling patient (patients who might be uncomfortable with the responsibility of making choices regarding their care). **Adjustment/Stratification:** **Level of Analysis:** Individual Clinician **Type of Measure:** Process **Data Source:** Administrative claims, Paper Medical Records **Measure Steward:** American Urological Association
MEMBER COMMENTS (August 7-21, 2012)
America's Health Insurance Plans - This measure assesses standard practice and it would be difficult to assess how well counseling is performed.
STEERING COMMITTEE MEETING (August 27-28, 2012)
1. Importance to Measure and Report: **1a.** High Impact: **H-12; M-3; L-0; I-0** **Discussion:** There is general agreement this measure focus addresses a high impact area. **1c.** Evidence

C 2050 Patient counseling on treatment options, including behavioral and surgical treatments prior to Stress Urinary Incontinence (SUI) surgery

3: Yes, body of evidence meets guidance for quantity, quality, consistency
3: No, body of evidence does not meet guidance for quantity, quality, consistency
9: No, inadequate information to rate quantity, quality, consistency of body of evidence

Discussion:

- Guidelines were submitted from European and US guidelines, but there was no direct evidence submitted to support that counseling will improve outcomes for women with SUI.
- This concept represents the standard of care. The Committee discussed whether this focus area is worthy of a national quality measure.
- They also discussed the ability for surgeons to game the system and document they counseled when they in fact did not counsel patients on treatment options.
- There is, however, a large body of evidence about shared decision making that suggest that when you counsel patients in general it leads to better outcomes; this general body of evidence would apply and support this specific measure focus.
- The Committee agreed that the information exists, but it was not provided in the measure submission.
- *There is general agreement that the quantity, quality, and consistency of the body of evidence meet the NQF guidance*: **Y-15; N- 0**

1b. Performance Gap: **H-3; M-11; L-1; I-0**

Discussion:

- While the data presented does not represent of the gap in the US population, the Committee agreed based on clinical experience that patient expectations for surgery are often not representative of actual cure rates.

Recommendations to Developer for Stage 2:

- Reconsider the exclusions specified in this concept: excluding people for medical reasons or for cognitive impairment are not reasons for not having a work up.
- Patient reasons for not counseling are not precise.
- Combine with C 2049 to include both components of care in the numerator for the same population in the denominator.
- Potential risks and treatment options discussed should be broadened to include biofeedback, medications, and especially the use of surgical mesh.

Steering Committee Recommendation for Approval of Concept: Y-15; N- 0

C 2052 Reduction of Complications through the use of Cystoscopy during Surgery for Stress Urinary Incontinence (SUI)

Measure Concept Submission Form
Status: New Submission
Description: Percentage of SUI surgeries for which cystoscopy was used during the surgical procedure to reduce complications
Numerator Statement: Female patients who had SUI surgery for which cystoscopy was used during the

C 2052 Reduction of Complications through the use of Cystoscopy during Surgery for Stress Urinary Incontinence (SUI)

surgical procedure to reduce complications

Denominator Statement: Female patients who had SUI surgeries (without concomitant surgery for prolapse)

Exclusions: Documentation of medical reason(s) for not using cystoscopy during SUI surgery (patients for whom the use of a cystoscope may not be appropriate, such as the presence of a new cystostomy repair). The panel noted that endoscopy after a new repair should be cautiously used. Concomitant prolapse surgery is an exclusion.

Adjustment/Stratification:

Level of Analysis: Individual Clinician

Type of Measure: Process

Data Source: Administrative claims, Paper Medical Records

Measure Steward: American Urological Association

MEMBER COMMENTS (August 7-21, 2012)

America's Health Insurance Plans - We recommend revising the measure name to more accurately reflect measurement of the number of women who have had complications through the use of cystoscopy during surgery for Stress Urinary Incontinence. Also, it will be difficult to identify appropriate denominator exclusions through administrative data and will require burdensome chart abstraction.

STEERING COMMITTEE MEETING (August 27-28, 2012)

1. Importance to Measure and Report:

1a. High Impact: **H-13; M-2; L-0; I-0**

Discussion: There is general agreement this measure focus addresses a high impact area. SUI surgery is a high volume procedure and cystoscopy is used to reduce complications.

1c. Evidence

5: Yes, body of evidence meets guidance for quantity, quality, consistency

9: No, body of evidence does not meet guidance for quantity, quality, consistency

Discussion:

- The evidence to support the three guidelines (European Urology, AUA, ACOG) submitted are all consensus based and no further systematic review of the evidence was performed or documented in the submission form.
- Due to the lack of information in the evidence portion of the submission form, the Committee focused their discussion on the information submitted in the performance gap section. The submission subsequently notes the improved rates of identifying injuries during surgery with the use of cystoscopy are based on three observational studies. The Committee weighed this conflicting information, the controversy over cost effectiveness, the possible surgical techniques that can be used, the risk to the patient to perform the cystoscopy, and determined it is low risk (1% chance of bladder infection) and high benefit for the patient. The GU experts agreed that there is general consensus that this

C 2052 Reduction of Complications through the use of Cystoscopy during Surgery for Stress Urinary Incontinence (SUI)
should be done; while the rate of injury may be low, the consequences of not identifying an injury are very high. • Within their discussion, the Committee rated the evidence as low quality, moderate quantity, and consistency is high for use of cystoscopy. • The evidence does not exist at all to support the measure focus.(i.e., no empirical evidence). • *There's an exceptional and compelling reason that the measure should be considered further (i.e., benefits outweigh the harms):* **Y-13; N- 2** **1**: No, inadequate information to rate quantity, quality, consistency of body of evidence **1b.** Performance Gap: **H-2; M-7; L-4; I-2** **Discussion:** While the information submitted for the performance gap was inconsistently presented, there was general agreement that based on the Committee's expert opinion there is a moderate gap in performance.
Recommendations to Developer for Stage 2: • Exclusions: concomitant surgery should not be excluded. • Gap information needs to be improved. • Measure should be stratified by procedure. • Feasibility and usability of this measure may be impacted by the inability to capture all the cystoscopies with available codes. • Combine with C2063.
Steering Committee Recommendation for Approval of Concept: Y-11; N- 4

C 2063 Use of cystoscopy concurrent with prolapse repair surgery
Measure Concept Submission Form **Status:** New Submission **Description:** Percentage of patients that undergo concurrent cystoscopy at the time of surgery for correction of anterior and/or apical vaginal prolapse to check for lower urinary tract injury. **Numerator Statement:** Numerator is the number of female patients where a concurrent intraoperative cystoscopy was performed at the time of surgery for correction of anterior and/or apical vaginal prolapse to check for lower urinary tract injury. **Denominator Statement:** Denominator is the number of female patients undergoing any prolapse repair surgery for correction of anterior and/or apical vaginal prolapse. **Exclusions:** There are no exclusions from the target population. **Adjustment/Stratification:** We are not planning to risk adjust this measure. We do not plan to stratify the results. **Level of Analysis:** Clinician Group/Practice, Individual Clinician **Type of Measure:** Process **Data Source:** Administrative claims, Paper Medical Records **Measure Steward:** American Urogynecologic Society
MEMBER COMMENTS (August 7-21, 2012)

C 2063 Use of cystoscopy concurrent with prolapse repair surgery
America's Health Insurance Plans - We are concerned that this measure does not meet the importance criterion as it does not focus on a demonstrated high-impact aspect of healthcare. Also, this measure is not easily collected through administrative data and will require burdensome chart abstraction. We recommend combining this measure with #C 2038 into a single prolapse surgery measure.
STEERING COMMITTEE MEETING (August 27-28, 2012)
1. Importance to Measure and Report: **1a.** High Impact: **H-8; M-6; L-0; I-0** **Discussion:** There is general agreement this measure focus addresses a high impact area. **1c.** Evidence **12**: Yes, body of evidence meets guidance for quantity, quality, consistency **Discussion:** There is a moderate amount of evidence on the use of cystoscopy used specifically in prolapse surgery; however, if evidence related to hysterectomy is included the body of evidence is broader to support the measure focus. These procedures are similar enough that the evidence can be considered applicable to both procedures. The Committee agreed the concept meets the evidence criteria. **2**: No, body of evidence does not meet guidance for quantity, quality, consistency **0**: No, inadequate information to rate quantity, quality, consistency of body of evidence **1b.** Performance Gap: **H-1; M-10; L-3; I-0** **Discussion:** Based on the data provided for this concept, the Committee agrees there is a performance gap and an opportunity for improvement.
Recommendations to Developer for Stage 2: • Consider how data will be collected to implement this measure. The use of CPT codes to identify cystoscopy (that is bundled with anterior repair) may be an issue for validity and reliability testing in stage 2. • Combine with other related measures: C 2052 Reduction of Complications through the use of Cystoscopy during Surgery for Stress Urinary Incontinence (SUI).
Steering Committee Recommendation for Approval of Concept: Y-14; N- 0

GI Concepts Recommended for Approval

0622 GERD - Upper Gastrointestinal Study in Adults with Alarm Symptoms
Measure Concept Submission Form **Status:** Maintenance, Original Endorsement: December 4, 2009 **Description:** The percentage of adult patients with gastroesophogeal reflux disease (GERD) with alarm symptoms who have had an upper gastrointestinal study. **Numerator Statement:** Patients who have had an upper gastrointestinal study

0622 GERD - Upper Gastrointestinal Study in Adults with Alarm Symptoms

Denominator Statement: Patients, 18 years and older, diagnosed with GERD with alarm symptoms (e.g., dysphagia, iron deficiency anemia, weight loss)

Exclusions: Specific Exclusions:

1. Patients with a documented gastrointestinal malignancy

2. Patients with other causes of the alarm symptoms including esophageal varices, known Barrett's esophagus, or gastric restrictive procedures

General Exclusions:

Metastatic malignancy, chemotherapy/radiation therapy, hospice and Skilled Nursing Facility, feedback from physician indicating GI study contraindicated or not applicable.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: National, Regional

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Patient Reported Data/Survey, Electronic Clinical Data : Pharmacy

Measure Steward: ActiveHealth Management

MEMBER COMMENTS (August 7-21, 2012)

America's Health Insurance Plans - This measure cannot be easily collected through administrative data and will require burdensome chart abstraction; however, it is a good registry measure. We are also concerned that as written, the "sensitivity" of the measure appears to be problematic (issues with identifying appropriate use) and could therefore falsely suggest overuse.

STEERING COMMITTEE MEETING (August 27-28, 2012)

1. Importance to Measure and Report:

1a. High Impact: **H-2; M-7; L-5; I-1**

Discussion:

- The Committee discussed the seemingly small number of patients that would be captured in this measure given the measure focus. Based on the data provided, it appears to be a small population of people who actually have alarm symptoms that would be impacted by this measure; patients with GERD and with alarm symptoms are a very small population. Given the severity and implications for treatment of the small population represented by the measure, this measure focus could be impactful. It is potentially a vulnerable population. The Committee also expressed some concerns about physician documentation and capturing dysphagia and weight loss with administrative claims data. It is very difficult to identify these patients.
- These questions around definitions and issues of validity and reliability will become important in stage 2.

1c. Evidence

4: Yes, body of evidence meets guidance for quantity, quality, consistency
1: No, body of evidence does not meet guidance for quantity, quality, consistency
10: No, inadequate information to rate quantity, quality, consistency of body of evidence

Discussion:

0622 GERD - Upper Gastrointestinal Study in Adults with Alarm Symptoms
• The sensitivity of the practice to identify cancers in patients with alarm symptom is about 67%, which is equivalent to other cancer screening tests like PSA and mammography. • *There is general agreement that the quantity, quality, and consistency of the body of evidence meet the NQF guidance*: **Y-10; N- 5** **Discussion:** The Committee agreed there is significantly more evidence available on this measure focus than was presented in the submission. While the Committee agreed the evidence submitted was insufficient, there was agreement that they would exercise the evidence exception to continue to review the concept, since the quality, quantity, and consistency of the evidence would support this measure focus if provided. **1b.** Performance Gap: **H-0; M-2; L-13; I-0** **Discussion:** • Overutilization of esophagogastroduodenoscopy (EGD) is very common so there was some concern on whether there is actually underutilization for this population. • From the specialist standpoint there is likely not a major performance gap, but for Primary Care Providers (PCP) there may be a larger performance gap. • This maintenance measure is currently tested only at the population level and the Committee raised concerns on the usability of this measure at that level. This will be discussed in Stage 2.
Recommendations to Developer for Stage 2: • This measure should include chronic GERD patients. • The exclusion should be clarified as previous malignancy. • Barrett's esophagus should be included. • The measure should be expanded to include patients under 18 as well; pediatric populations should be included as the same evidence applies. • Additional evidence should be provided for evidence criterion. • Additional information on performance gap is needed. • Define/specify the testing/procedures for the numerator more clearly. • Consider specifying the numerator in a patient population in which it would have more broadly impact (e.g., obese and/or male patients)
Steering Committee Recommendation for Approval of Concept: Y-14; N- 1 **Discussion:** The concept has been recommended for approval, but the lack of performance gap for the current concept will need further consideration as the measure is fully evaluated in Stage 2.

0635 Chronic Liver Disease - Hepatitis A Vaccination
Measure Concept Submission Form **Status:** Maintenance, Original Endorsement: December 4, 2009 **Description:** The percentage of adult patients with chronic liver disease who have received a hepatitis A

0635 Chronic Liver Disease - Hepatitis A Vaccination

vaccine

Numerator Statement: Patients with chronic liver disease who have received a hepatitis A vaccine or who have been tested for immunity in the past. Keeping in consideration that providers who test for Hepatitis A immunity most likely intend to take action on the test results and that hepatitis A testing is usually communicated in the form of LOINC codes which do not indicate immunity confirmed , immunity testing is considered sufficient for completion of the numerator for this measure.

Denominator Statement: All patients, ages 18 and older, diagnosed with chronic liver disease

Exclusions: Patients with a previous history of viral hepatitis A. General exclusions: 1. Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months; 2. Patients who have been in a skilled nursing facility in the last 3 months (this exclusion is included to avoid holding physicians who care for patients during a transitional period, e.g. temporary SNF placement, for their ongoing care; hence, the time limitation of 3 months).

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment necessary None

Level of Analysis: Population : National, Population : Regional

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Electronic Clinical Data : Laboratory, Patient Reported Data/Survey, Electronic Clinical Data : Pharmacy

Measure Steward: ActiveHealth Management

MEMBER COMMENTS (August 7-21, 2012)

America's Health Insurance Plans - While this measure can be calculated using administrative data, there may be challenges with assessing the numerator at the health plan level in instances where patients have received the vaccination but who have also changed health plans.

STEERING COMMITTEE MEETING (August 27-28, 2012)

1. Importance to Measure and Report:

1a. High Impact: **H-7; M-8; L-0; I-0**

Discussion: The developer cited literature that shows that chronic liver disease is quite prevalent and common, and the patients with chronic liver disease who develop hepatitis A often have higher rates of fulminant hepatitis and mortality.

1c. Evidence

13: Yes, body of evidence meets guidance for quantity, quality, consistency
1: No, body of evidence does not meet guidance for quantity, quality, consistency
1: No, inadequate information to rate quantity, quality, consistency of body of evidence

Discussion: The Committee agreed that the three guidelines cited by the developer were based on a moderate quality, quantity and high consistency level of evidence. The evidence was derived from both observational studies, time series studies and expert opinion supporting the guidelines.

1b. Performance Gap: **H-11; M-3; L-1; I-0**

Discussion: Based on the data provided for this maintenance measure from the ActiveHealth database there is a 64% performance gap. The Committee agrees this is a significant

0635 Chronic Liver Disease - Hepatitis A Vaccination
performance gap and an opportunity for improvement.
Recommendations to Developer for Stage 2: • The numerator is inconsistent with title of measure; consider changing the title of the measure to more closely align with the measure focus. • There could be a potential validity issue in stage 2 with the assumption this concept makes that if a person was tested, they were positive and received the vaccination. Consider how to address this issue. • Understanding there are differences in data sources, harmonize with #0399 under review in the NQF Infectious Disease project   ○ **Developer Response**: Developers acknowledged and agreed
Steering Committee Recommendation for Approval of Concept: Y-15; N- 0

0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients
Measure Concept Submission Form **Status:** Maintenance, Original Endorsement: January 17, 2011 (Time-limited) **Description:** Percentage of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report. **Numerator Statement:** Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report **Denominator Statement:** All patients aged 50 years and older receiving screening colonoscopy without biopsy or polypectomy **Exclusions:** Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, above average risk patient, inadequate prep) **Adjustment/Stratification:** No risk adjustment or risk stratification **Level of Analysis:** Clinician Group/Practice, Individual, Clinician/ Team **Type of Measure:** Process **Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Registry **Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
MEMBER COMMENTS (August 7-21, 2012)
None
STEERING COMMITTEE MEETING (August 27-28, 2012)
1. Importance to Measure and Report: **1a.** High Impact: **H-15; M-0; L-0; I-0** **Discussion:** There is general agreement this concept meets the high impact criterion. **1c.** Evidence **15**: Yes, body of evidence meets guidance for quantity, quality, consistency

0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients

Discussion:

- There is a significant amount of evidence to support this measure focus.
- There was discussion on whether the 10 year interval specified in this concept is based on evidence or consensus. Most polyps > 1 cm in diameter appear to grow for 5-10 years before becoming colorectal cancer. Usefulness of an interval beyond 10 years has not been studied. Committee members noted that prospective studies have demonstrated that very few patients (< 3%) have advanced adenomas when colonoscopy is repeated 5 years after a normal screening colonoscopy. Evidence in the submission form was not graded, but it is supported in the guidelines.

0: No, body of evidence does not meet guidance for quantity, quality, consistency
0: No, inadequate information to rate quantity, quality, consistency of body of evidence

1b. Performance Gap: **H-15; M-0; L-0; I-0**

Discussion: Based on the data provided for this maintenance measure, the Committee agrees there is still a performance gap and an opportunity for improvement.

Recommendations to Developer for Stage 2:

- Rather than measuring whether the appropriate interval was recommended, consider specifying the measure, for example, patients aged 60 years or older receiving a screening colonoscopy who are documented to have had their last screening colonoscopy 10 or more years prior. Implementing these changes would make the measure closer to an outcome measure that would be more impactful. The Committee recognized that to implement a prospective outcome measure is difficult based on availability of data.
- Patients aged 50 years and older receiving a screening colonoscopy who had a recommendation to repeat colonoscopy in 1 year or less due to poor bowel cleansing
- Consider adjusting the upper age limit for older patients, including inflammatory bowel disease, and better define "above average risk".
- Clarify in the specifications whether the exceptions are included in the denominator or should be calculated as a separate measure.
- Due to the differences in populations and the measure focus, harmonization between this concept and 0659 will not be needed.

Steering Committee Recommendation for Approval of Concept: Y-15; N- 0

0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use

Measure Concept Submission Form

Status: Maintenance, Original Endorsement: Jan 17, 2011 (Time-limited)

Description: Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp in previous colonoscopy findings who had a follow-up interval of 3 or more years since their last colonoscopy documented in the colonoscopy report

0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use

Numerator Statement: Patients who had an interval of 3 or more years since their last colonoscopy

Denominator Statement: All patients aged 18 years and older receiving a surveillance colonoscopy with a history of a prior colonic polyp in a previous colonoscopy

Exclusions: Documentations of medical reason(s) for an interval of less than 3 years since the last colonoscopy (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas)

OR

Documentation of a system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy report was incomplete)

Adjustment/Stratification: No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. Stratification by insurance coverage (Commercial, Medicare and Medicaid) is recommended by some implementers.

Level of Analysis: Clinician Group/Practice, Individual, Clinician/Team

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Registry

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

MEMBER COMMENTS (August 7-21, 2012)

None

STEERING COMMITTEE MEETING (August 27-28, 2012)

1. Importance to Measure and Report:

1a. High Impact: **H-15; M-0; L-0; I-0**

Discussion: There is general agreement this measure focus addresses a high impact area as it is one of the most overused procedures.

1c. Evidence

14:Yes, body of evidence meets guidance for quantity, quality, consistency

Discussion:

- The Committee discussed the length of screening intervals and the yield of identifying adenomas.
- The Committee reviewed evidence cited in the guidelines that was not specifically provided by the measure developer. Based on this review, the Committee determined that there is high quality of evidence demonstrating that these are appropriate intervals, and that the expected benefits are consistent.
- The interval specified in the measure does not match the recommendations in the evidence 3+ years versus 5 years

0: No, body of evidence does not meet guidance for quantity, quality, consistency

1: No, inadequate information to rate quantity, quality, consistency of body of evidence

0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use
1b. Performance Gap: **H-4; M-10; L-0; I-1** **Discussion:** • While the PQRS data does not suggest a performance gap, few physicians reported on this measure. However, the Committee did not believe that the submitted data is representative of the likely performance gap. The use of EHRs for this measure could demonstrate a larger performance gap. PQRS also only takes patients 65 years and older, so it is not capturing patients in the commercial population.
Recommendations to Developer for Stage 2: • The developer should expand on the available evidence and on the details of the meta-analysis to better demonstrate the body of evidence available to support this measure focus. • eMeasure specifications should be submitted in stage 2. • The interval specified in the measure does not match the recommendations in the evidence 3+ years versus 5 years; consider how these can be aligned to ensure the measure is evidence-based. • Due to the differences in populations and the measure focus, harmonization between this concept and 0658 will not be needed.
Steering Committee Recommendation for Approval of Concept: Y-15; N- 0

C 2059 Inflammatory Bowel Disease (IBD) preventive care: corticosteroid sparing therapy
Measure Concept Submission Form **Status:** New Submission **Description:** Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease (IBD) who have been managed by corticosteroid* greater than or equal to 10mg/day for 60 or greater consecutive days that have been prescribed corticosteroid sparing therapy in the last reporting year. **Numerator Statement:** Patients managed with corticosteroids greater than or equal to 10mg/day for 60 or greater consecutive days AND prescribed a corticosteroid sparing therapy (e.g. thiopurines, methotrexate, or anti-TNF agents). **Denominator Statement:** All patients aged 18 years and older with a diagnosis of inflammatory bowel disease. **Exclusions:** PQRS: Documentation of medical reason(s) for not treating with corticosteroid sparing therapy (e.g., toxicity,allergy,loss of effectiveness). In the AGA Digestive Health Recognition Program (TM) because of the use of clinical data those that have not received a dose of corticosteroids greater than or equal to 10mg/day for 60 or greater consecutive days are excluded from the denominator. We have also been able to include a patient exclusion for example if the patient refuses steroid sparing therapy. **Adjustment/Stratification:** **Level of Analysis:** Individual Clinician **Type of Measure:** Process **Data Source:** Electronic Clinical Data : Registry **Measure Steward:** American Gastroenterological Association

C 2059 Inflammatory Bowel Disease (IBD) preventive care: corticosteroid sparing therapy

MEMBER COMMENTS (August 7-21, 2012)

- *America's Health Insurance Plans* - This measure is appropriate for registry use as it is difficult to obtain data from other sources.
- *American College of Gastroenterology* - The College supports the measure in concept. However, we recommend that the measure developer provide clearer guidance on the denominator, and more specifically, the patient population excluded from the denominator. We also seek guidance on whether this measure is designed for only reporting quality measures via the Medicare Physician Quality Reporting System (PQRS) or when using the AGA Digestive Health Recognition Program as outlined in the submission.

  In order to promote wide adoption of this measure and a clearer understanding of the relevant patient population in the denominator exclusions, we also recommend that for Stage 2 the measure developer provide a description that is without reference to PQRS or a specific registry, and instead, use common current procedural terminology (CPT) codes or specifications clearly outlining the relevant population. The College also recommends adding budesonide in the measure specifications as it is a steroid and should be included in a measure regarding corticosteroid sparing therapy.

STEERING COMMITTEE MEETING (August 27-28, 2012)

1. Importance to Measure and Report:

1a. High Impact: **H-14; M-0; L-0; I-0**

Discussion: There is general agreement this measure focus addresses a high impact area. IBD is a common problem and chronic use of steroids is a serious/complicated issue. Approximately 1.4 million in US population have IBD.

1c. Evidence

14: Yes, body of evidence meets guidance for quantity, quality, consistency

Discussion: The Committee agreed that the consistency of the evidence submitted is high, the quality is moderate and the quantity is high. This concept meets the evidence criterion.

0: No, body of evidence does not meet guidance for quantity, quality, consistency

0: No, inadequate information to rate quantity, quality, consistency of body of evidence

1b. Performance Gap: **H-0; M-13; L-1; I-0**

Discussion:

- In the data submitted, there was only a small study that demonstrated a performance gap. However, the Committee agreed that there is sufficient variation in clinical practice to warrant measurement.
- The data on racial disparities for this measure focus is more abundant; low SES patients do not generally have access to some of the alternative medications that can be cost prohibitive.
- The Committee agreed there is moderate gap in performance in this.

Recommendations to Developer for Stage 2:

C 2059 Inflammatory Bowel Disease (IBD) preventive care: corticosteroid sparing therapy
• Re-examine exclusions and the denominator to ensure it clearly defined. • It is questionable whether administrative claims can be used as a data source for this measure. To be effective, the denominator should include patients with IBD who are on chronic steroids; the Committee recognizes that the CPT-II codes that they have decided to use for the measures will make this difficult. • Consider inclusions of patients on steroids for greater than 60 days in the numerator. • Consider changing the denominator statement: add "AND on corticosteroids." • Expand the denominator to include the pediatric population. • Consider adding a component on whether a consult was made for surgery as a corticosteroid sparing therapy. • Consider how patients who refuse treatment will be measured. • Consider eMeasure specifications. • Consider whether a more general measure focusing on long-term steroid therapy preventative care that would include components of C2062 (not recommended) would be more inclusive of care for this population.
Steering Committee Recommendation for Approval of Concept: Y-14; N- 0

C 2065 Gastrointestinal Hemorrhage Mortality Rate (IQI #18)
Measure Concept Submission Form **Status:** New Submission **Description:** Percent of discharges with an in-hospital death among cases with a principal diagnosis of gastrointestinal hemorrhage **Numerator Statement:** Number of in-hospital deaths among cases meeting the inclusion and exclusion rules for the denominator **Denominator Statement:** All discharges, age 18 years and older, with a principal diagnosis code of gastrointestinal hemorrhage **Exclusions:** Exclude cases: • transferring to another short-term hospital • MDC 14 (pregnancy, childbirth, and puerperium) • with missing discharge disposition, gender, age, quarter, year or principal diagnosis **Adjustment/Stratification:** The predicted value for each case is computed using a two-stage hierarchical model (the first stage is a logistic regression using Generalized Estimating Equations (GEE) to account for clustering of patients within hospitals; the second stage is a reliability weight). The covariates in the logistic regression include age (in 5-year age groups pooled), APR-DRG and APR-DRG Risk of Mortality subclass, MDC and transfer-in status. The reference population used in the regression is the universe of discharges for states that participate in the HCUP State Inpatient Data (SID) for the years 2008, a database consisting of 42 states and approximately 30 million adult discharges. INTERCEPT AGE 18 to 59 AGE 65+ APR-DRG '2201' (e.g., APR-DRG 220, Risk of Mortality level 1) APR-DRG '2202' (e.g., APR-DRG 220, Risk of Mortality level 2) APR-DRG '2203' (e.g., APR-DRG 220, Risk of Mortality level 3)

C 2065 Gastrointestinal Hemorrhage Mortality Rate (IQI #18)
APR-DRG '2204' (e.g., APR-DRG 220, Risk of Mortality level 4) APR-DRG '2211' APR-DRG '2212' APR-DRG '2213' APR-DRG '2214' APR-DRG '2411' to '2413' APR-DRG '2414' APR-DRG '2421' to '2423' APR-DRG '2424' APR-DRG '2441' to '2442' APR-DRG '2443' APR-DRG '2444' APR-DRG '2532' APR-DRG '2533' APR-DRG '2534' APR-DRG '2541' to '2534' APR-DRG '2544' MDC Other TRNSFER Transfer-in Detailed risk model available at http://www.qualityindicators.ahrq.gov/Downloads/Modules/IQI/V44/Risk%20Adjustment%20Tables%20IQI%204.4.pdf APR-DRG category labels at http://hcup-us.ahrq.gov/db/nation/nis/v261_aprdrg_meth_ovrview.pdf **Level of Analysis:** Facility **Type of Measure:** Outcome **Data Source:** Administrative claims **Measure Steward:** Agency for Healthcare Research and Quality
MEMBER COMMENTS (August 7-21, 2012)
America's Health Insurance Plans - This measure may be subject to a small numbers problem raising reliability issues.
STEERING COMMITTEE MEETING (August 27-28, 2012)
1. Importance to Measure and Report: **1a.** High Impact: **H-14; M-0; L-0; I-0** **Discussion:** There is general agreement this measure focus addresses a high impact area. GI hemorrhage is a common problem. **1c.** Evidence **14**: Yes, body of evidence meets guidance for quantity, quality, consistency **Discussion:** Outcome measures do not require evidence; however, the Committee

C 2065 Gastrointestinal Hemorrhage Mortality Rate (IQI #18)
agreed that the developer did provide a rationale that supports the relationship of the health outcome to processes or structures of care. **0**: No, body of evidence does not meet guidance for quantity, quality, consistency **0**: No, inadequate information to rate quantity, quality, consistency of body of evidence **1b.** Performance Gap: **H-10; M-4; L-0; I-0** **Discussion:** • The odds ratio of bleeding ranges from 17 to 22 based on the type of hospital and from 14 to 25 based on insurance status. • Risk adjusted using 3M APR-DRG's and it is publicly available to implement this measure. While gender is included in the risk adjustment model, race and ethnicity are not. This allows for stratification by race and ethnicity as the data submitted demonstrates significant differences in the outcomes among white, black, and hispanic patients. • The Committee agreed based on the above discussions, that there is a performance gap for this measure focus.
Recommendations to Developer for Stage 2: • Numerator and denominator only include patients with primary diagnosis of GI bleed, consider how this might impact the capture of other patients with GI bleed who do not have it has a primary diagnosis. • Consider stratifying by esophageal bleeds and lower GI bleeds.
Steering Committee Recommendation for Approval of Concept: Y-14; N- 0

GU Concepts Not Recommended for Approval

C 2037 Objective characterization of pelvic organ prolapse prior to surgery
Measure Concept Submission Form **Status:** New Submission **Description:** Percentage of female patients with a characterization of the degree of prolapse in each vaginal compartment, using a validated, objective measurement system(e.g.POP-Q or Baden/Walker) within 12 months of surgery for pelvic organ prolapse. **Numerator Statement:** The number of female patients whose pelvic organ prolapse was documented using a validated, objective measurement tool (i.e.POP-Q or Baden/Walker Halfway System) performed within the 12 months prior to surgery for pelvic organ prolapse. **Denominator Statement:** All patients undergoing pelvic organ prolapse (POP) surgery. **Exclusions:** There are no exclusions. **Adjustment/Stratification:** We do not plan to risk adjust the measure. We do not plan to stratify the measure results. **Level of Analysis:** Clinician Group/Practice, Individual Clinician **Type of Measure:** Process **Data Source:** Administrative claims, Paper Medical Records **Measure Steward:** American Urogynecologic Society
MEMBER COMMENTS (August 7-21, 2012)

C 2037 Objective characterization of pelvic organ prolapse prior to surgery

America's Health Insurance Plans - We are concerned that this measure does not meet the importance criterion as it does not focus on a demonstrated high-impact aspect of healthcare. While we recognize that this measure is designed to assess appropriateness of care, we believe better measures of appropriateness that are not clinical processes of care measures need to be developed. This measure will also require burdensome chart abstraction.

STEERING COMMITTEE MEETING (August 27-28, 2012)

1. Importance to Measure and Report:

1a. High Impact: **H-9; M-5; L-0; I-0**

Discussion: The Committee agreed that characterizing the type of prolapse does impact the type of surgery that should be performed. There is general agreement this is a high impact measure focus.

1c. Evidence

1: Yes, body of evidence meets guidance for quantity, quality, consistency

12: No, body of evidence does not meet guidance for quantity, quality, consistency

Discussion:

- The evidence submitted for this concept does not specifically address the measure focus. Evidence is high quality but addresses the tools suggested by the measures not the actual characterization. The Committee agreed that there is no evidence to support this measure focus.
- *There is an exceptional and compelling reason that the measure should be considered further (i.e., benefits outweigh the harms):* **Y-3; N- 11**

1: No, inadequate information to rate quantity, quality, consistency of body of evidence

1b. Performance Gap:

Discussion: There was no discussion of gap as the concept did not pass evidence.

Recommendations to Developer:

- For future submissions on this topic, identify more evidence to suggest improper characterization results in poorer outcomes.
- There is opportunity for a better measure that is more proximal to the outcome. Consider developing an outcome measure of appropriateness of the surgery and patient reported improvement in outcomes.

Steering Committee Recommendation for Approval of Concept:

Discussion: This concept is not recommended for approval. The concept did not pass the evidence criterion.

C 2051 Patients Counseled About Risks Associated with the Use of Mesh in Sling Surgery Prior to Surgery

Measure Concept Submission Form

C 2051 Patients Counseled About Risks Associated with the Use of Mesh in Sling Surgery Prior to Surgery

Status: New Submission

Description: Percentage of female patients who undergo mesh sling surgery for whom there was documentation that they were counseled about the risks associated with the use of mesh in sling surgery (erosion/extrusion, pain, permanence) prior to surgery

Numerator Statement: Female patients who undergo mesh sling surgery for whom there was documentation that they had been counseled about the risk of mesh erosion/extrusion, pain, and permanence prior to performing a mesh sling surgery

Denominator Statement: All female patients who undergo Mesh sling surgery (without concomitant surgery for prolapse)

Exclusions: Documentation of medical reason(s) for not performing a complete workup for assessment of stress urinary incontinence (such as use of a nonsynthetic material for the sling; conomitant prolapse; cognitive impairment limiting characterization of SUI--information might be obtained via caregiver).

Adjustment/Stratification:

Level of Analysis: Individual Clinician

Type of Measure: Process

Data Source: Administrative claims, Paper Medical Records

Measure Steward: American Urological Association

MEMBER COMMENTS (August 7-21, 2012)

America's Health Insurance Plans - This is a process measure and assesses documentation of patient counseling. This measure cannot be easily collected through administrative data and will require burdensome chart abstraction.

STEERING COMMITTEE MEETING (August 27-28, 2012)

1. Importance to Measure and Report:

1a. High Impact: **H-9; M-3; L-2; I-1**

Discussion: The Committee agreed this concept meets the criterion for high impact.

1c. Evidence

5: Yes, body of evidence meets guidance for quantity, quality, consistency

7: No, body of evidence does not meet guidance for quantity, quality, consistency

Discussion:

- The evidence submitted was not linked to the measure focus of counseling, but rather the outcomes associated with the use of mesh. In addition to the US FDA warning, most of the evidence is European. The data collection for this measure would overlap with the informed consent process for this surgery.
- The Committee discussed the link between counseling and decreasing sling surgeries or erosions.
- The risks of using mesh is clearly important, but since the denominator for this concept only includes patients who have had the surgery, the desired outcome to decrease mesh surgeries and complications is not captured with this measure.

C 2051 Patients Counseled About Risks Associated with the Use of Mesh in Sling Surgery Prior to Surgery
• The Committee agreed the evidence does not exist to support the measure focus (i.e., no empirical evidence). • *There is an exceptional and compelling reason that the measure should be considered further (i.e., benefits outweigh the harms):* **Y-4; N- 11** **3**: No, inadequate information to rate quantity, quality, consistency of body of evidence **1b.** Performance Gap: **Discussion:** There was no discussion of gap as the measure did not pass evidence.
Recommendations to Developer: • Consider combining this measure with one of the other similar measures where there is a broader denominator that is not limited to patients who have already had the mesh surgery.
Steering Committee Recommendation for Approval of Concept: **Discussion**: This concept is not recommended for approval. The concept did not pass the evidence criterion.

C 2054 Assessment of treatment within one year of Stress Urinary Incontinence (SUI) surgery
Measure Concept Submission Form **Status:** New Submission **Description:** Percentage of female patients who had SUI surgery, who had an assessment of response to surgical treatment performed within 1 year post-surgery **Numerator Statement:** Female patients without concomitant prolapse who had SUI surgery and who received the following as part of their postoperative assessment within one year: • Characterization of incontinence: focused history (questions asked of patient: duration of incontinence; number of episodes; use of protective products, i.e. "bother") • focused physical exam • post void residual analysis • urinary analysis, and urinary culture, if indicated **Denominator Statement:** Female patients who had SUI surgery without concomitant surgery for prolapse seen at follow up within one year post-treatment Patients with concomitant surgery for prolapse were excluded from the denominator because these measures are based on the AUA SUI guidelines which focused on an index patient without concomitant prolapse surgery. Prolapse surgery patients complicate the interpretation of the quality measures for SUI surgery such as characterization of prolapse symptoms, documentation of the involved compartments, and the severity of prolapse of each of the compartments as part of the physical exam. These elements are not necessary for stress incontinence patients. **Exclusions:** Documentation of medical reason(s) for not performing all or one of these elements (concomitant prolapse). Documentation of patient reason(s) for not performing all or one of these elements (inability to make and keep an appointment with the treating physician due to relocation, incapacity, and inability to travel). Documentation of system reason(s) for not performing all or one of these elements (visits are not reimbursable by the patient's insurer) **Adjustment/Stratification:**

C 2054 Assessment of treatment within one year of Stress Urinary Incontinence (SUI) surgery

Level of Analysis: Individual Clinician
Type of Measure: Process
Data Source: Administrative claims, Paper Medical Records
Measure Steward: American Urological Association

MEMBER COMMENTS(August 7-21, 2012)

America's Health Insurance Plans - We are concerned that this is already the standard of care patients should be receiving. We recommend revising the exclusionary criteria so that patients whose visits are not reimbursable by an insurer are captured in the denominator. Follow-up visits are often included in the package of services for which insurers make a bundled payment.

STEERING COMMITTEE MEETING (August 27-28, 2012)

1. Importance to Measure and Report:

1a. High Impact: **H-2; M-7; L-4; I-1**

Discussion: The Committee agreed this concept meets the criterion for high impact.

1c. Evidence

0: Yes, body of evidence meets guidance for quantity, quality, consistency
13: No, body of evidence does not meet guidance for quantity, quality, consistency

Discussion:

- The evidence section of this submission form was incomplete and did not list any guidelines or evidence to support the measure focus. The Committee experts were unable to identify any significant literature or evidence to support this measure focus.
- *There is an exceptional and compelling reason that the measure should be considered further (i.e., benefits outweigh the harms):* **Y-4; N- 10**

1: No, inadequate information to rate quantity, quality, consistency of body of evidence

1b. Performance Gap:

Discussion: There was no discussion of gap as the measure did not pass evidence.

Recommendations to Developer:

- The time period for this measure is a concern; day 1 to 365 is too wide.
- Consider another measure that focuses on the desired outcome related to this measure focus or a process that is linked closer to the desired outcome. The collection of more data points related to complications would make it more useful.

Steering Committee Recommendation for Approval of Concept:

Discussion: This concept is not recommended for approval. The concept did not pass the evidence criterion.

GI Concepts Not Recommended for Approval

C 2056 Colonoscopy Quality Index

Measure Concept Submission Form

Status: New Submission

Description: This is a composite measure of the percentage of patients undergoing screening or surveillance colonoscopy who meet all individual quality elements (Appropriate indication for colonoscopy, standardized assessments of medical risk and bowel preparation, complete examination with photo documentation, free of serious complications, withdrawal time recorded, all essential polyp information recorded if polyp(s) identified, recommendation for follow-up colonoscopy consistent with patient history and examination findings), and the completion rate of each individual quality element.

Numerator Statement: All patients undergoing screening or surveillance colonoscopy who meet all relevant individual quality elements (1. Appropriate indication for colonoscopy, 2. Standardized medical risk assessment, 3. Standardized assessment of bowel prep, 4. Complete examination, 5. Cecal photo taken, 6. All essential polyp information recorded, 7. Withdrawal time recorded, 8. Free of serious complication, 9. Appropriate follow-up recommendation). Elements that do not apply are excluded from numerator calculation.

Denominator Statement: All adults undergoing screening or surveillance colonoscopy

Exclusions: Patients with a personal or family history of familial adenomatous polyposis, hereditary non-polyposis colorectal cancer or inflammatory bowel disease are excluded from the denominator. Patients assessed as poor or unsatisfactory bowel preparation are excluded from the denominator.

Adjustment/Stratification: N/A - Procedural quality bundled measure. Although there is no data to support or refute, the quality of the colonoscopy procedure should not vary by case mix/risk as patients with a personal or family history of familial adenomatous polyposis, hereditary non-polyposis colorectal cancer or inflammatory bowel disease or patients assessed as poor or unsatisfactory bowel preparation are excluded from the denominator. These situations are excluded because of the need for highly individualized recommendations given the particular patient history and current clinical situation. This measure is not risk adjusted because it is a subgroup of low-risk patients; it does not make sense to risk adjust when there is minimal variation in risk for the population considered (e.g., all varying degrees of low risk). None

Level of Analysis: Facility, Clinician : Group/Practice, Clinician : Individual, Population : Regional

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Other, Paper Medical Records, Electronic Clinical Data : Registry

Measure Steward: Quality Quest for Health of Illinois, Inc.

MEMBER COMMENT (August 7-21, 2012)

American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy – See Letter

STEERING COMMITTEE MEETING (August 27-28, 2012)

1. Importance to Measure and Report:

1a. High Impact: **H-15; M-0; L-0; I-0**

Discussion:

- The focus for impact is on the broad area of colonoscopy screening surveillance.
- Colon cancer is the 2nd leading cause of cancer in the U.S.
- From a consumer perspective, the Committee agreed that composites are important and easily understood. There was general agreement that this measure focus addresses

a high impact area.

1c. Evidence

0: 1=Yes, body of evidence meets guidance for quantity, quality, consistency
12: 2=No, body of evidence does not meet guidance for quantity, quality, consistency

Discussion by component:

- 1. Appropriate Indication for Colonoscopy: The Committee agreed that good medical practice should include the indication and thus is not needed as a national consensus standard for quality measurement. The Committee agreed that the evidence submitted is based only on consensus opinion.
- 2. Standardized Medical Risk Assessment: The Committee reiterated that this is standard clinical practice with evidence that is based only on consensus opinion. Further, as part of a standardized medical risk assessment, a cardiac risk assessment is done.
- 3. Standardized assessment of bowel prep: The Committee agreed that this is an important component. Members discussed multiple registry/database studies that indicate the quality of the bowel prep results in improved adenoma detection rate; however, this evidence was not provided in the measure submission.
- 4 & 5 Complete Examination and Cecal Photo Taken: The Committee agreed that these are generally accepted as a standard of practice. These indicators demonstrate that the colonoscopy reached the cecum. The Committee agreed that there is strong evidence in terms of registry/database data and a RCT to support the notion that failure to reach the cecum is associated with a higher risk of having interval cancers but was not discussed on the submission form.
- 6 & 7 All essential polyp information recorded and withdrawal time recorded: The Committee agreed that there is evidence of endoscopic registry/database studies that demonstrate that if the withdrawal time is greater than 7 minutes, the adenoma detection rate is higher than if the withdrawal time is less than 7 minutes. Therefore, this information may be useful to record. However, Committee members noted that adenoma detection rate is the key quality indicator for colorectal cancer screening with colonoscopy since the purpose of this procedure is to identify and remove adenomas. There were concerns that these two indicators are not sufficiently related to the adenoma detection rate. The Committee noted evidence that endoscopists with withdrawal times of greater than seven minutes may still have poor adenoma detection rates. This evidence was not provided in the measure submission form. The Committee was also concerned that this component only requires that that the withdrawal time is recorded which can be “gamed” by the endoscopist so this may not improve outcomes. Others were also concerned that essential information about the polyp is not included in this measure, including whether pathologic examination of the polyp revealed it to be an adenoma. Low adenoma detection rate (but not short withdrawal time) has been associated with an increased risk of interval colorectal cancers.

C 2056 Colonoscopy Quality Index
• Across components 3-7: There is a focus on the endoscopist's ability to ensure that the entire colon has been examined and all polyps have been removed. The Committee discussed that these components ultimately try to assess whether the colonoscopy is going to minimize or prevent patients from getting colon cancer in the future. The Committee expressed concern that the evidence does not support the link of these processes to the outcome of interest, specifically the adenoma detection rate. • 8. Free of Serious Complications: In order to identify serious complications, the provider would need to follow up with the patient within a 15 to 30 day time window. The Committee discussed that documenting complications during the time of colonoscopy or in the first 24 hours after colonoscopy as this measure is currently specified would not assess the true rate of complications. While there is no disagreement that any complications experienced during the procedure should also be reported, the most common serious complication, post-polypectomy bleeding, usually does not occur until 2-14 days after colonoscopy and would not be captured by this indicator. The Committee was concerned that inclusion of only patients free of serious complications at the time of colonoscopy or in the first 24 hours after colonoscopy would not be an accurate representation of all complications that could occur. • The developer was asked to submit evidence for each of the nine composite components; however, the evidence submitted for most of the components was insufficient and repeated for each component. The Committee therefore voted on the evidence for all components of the composite in a single vote and agreed that the evidence submitted was insufficient. • The evidence submitted does not exist to support the measure focus (i.e., no empirical evidence) for all components of the composite. • *There is an <u>exceptional</u> and compelling reason that the measure should be considered further (i.e., benefits outweigh the harms):* **Y-0; N- 15** **3**: No, inadequate information to rate quantity, quality, consistency of body of evidence **1b.** Performance Gap: **Discussion:** There was no discussion of gap as the measure did not pass evidence.
Recommendations to Developer: • Consider weighting for the composite. • Evidence must be provided that is specific to each of the components. • Consider a composite that includes components with the highest evidence and impact, including a standardized assessment of bowel prep and completeness of colonoscopy including cecal photo taken that would indicate a failure to reach the cecum. Withdrawal time and serious complications within 14 days of colonoscopy should also be included. • An adenoma detection rate would be important to include in future composites.
Steering Committee Recommendation for Approval of Concept: **Discussion**: • The purpose of the composite is to allow consumers and purchasers to determine whether the colonoscopist is doing a quality job.

C 2056 Colonoscopy Quality Index
• The desired outcome of a colonoscopy should be to detect cancer (i.e. adenoma detection) and there is concern that this measure does not focus on processes that significantly impact that outcome. • This concept is not recommended for approval. The concept did not pass the evidence criterion, though the developer has submitted additional evidence that will considered during a post-comment conference call.

C 2062 Inflammatory Bowel Disease (IBD) preventive care: corticosteroid related iatrogenic injury – bone loss assessment
Measure Concept Submission Form **Status:** New Submission **Description:** Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease who have received dose of corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days were assessed for risk of bone loss once per the reporting year. **Numerator Statement:** Patients who have received dose of corticosteroids greater than or equal to 10mg/day for 60 or greater consecutive days who were assessed for risk of bone loss. **Denominator Statement:** All patients aged 18 years and older with a diagnosis of inflammatory bowel disease. **Exclusions:** There are no exclusions as specified for PQRS purposes. In the AGA Digestive Health Recognition Program (TM) because of the use of clinical data those that have not received a dose of corticosteroids greater than or equal to 10mg/day for 60 or greater consecutive days are excluded from the denominator. **Adjustment/Stratification:** **Level of Analysis:** Clinician : Individual **Type of Measure:** Process **Data Source:** Electronic Clinical Data : Registry **Measure Steward:** American Gastroenterological Association
MEMBER COMMENT (August 7-21, 2012)
None
STEERING COMMITTEE MEETING (August 27-28, 2012)
1. Importance to Measure and Report: **1a.** High Impact: **H-0; M-14; L-0; I-0** **Discussion:** There was general agreement that this measure focus has a moderate impact. The data submitted for this criterion only cited information from the United Kingdom and Canada. **1c.** Evidence **1**: Yes, body of evidence meets guidance for quantity, quality, consistency **5**: No, body of evidence does not meet guidance for quantity, quality, consistency **8**: No, inadequate information to rate quantity, quality, consistency of body of evidence **Discussion:** • There is no evidence to suggest that performing this test actually improves

C 2062 Inflammatory Bowel Disease (IBD) preventive care: corticosteroid related iatrogenic injury – bone loss assessment
outcomes. There were only two population-based studies cited. The quantity rating would be closer to moderate, but there is insufficient information to rate quality and consistency. The Committee agreed there is no evidence to support this measure focus. • *There is general agreement that the quantity, quality, and consistency of the body of evidence meet the NQF guidance*: **Y-0; N- 14** **1b.** Performance Gap: **Discussion:** There was no discussion of gap as the measure did not pass evidence.
Recommendations to Developer: • Further information on the evidence to support this concept is needed. • Consider whether a more general measure focusing on long-term steroid therapy preventative care that would include components of C2059 (recommended) would be more inclusive of care for this population. Again, more evidence would be required to support the bone loss assessment portion of the concept.
Steering Committee Recommendation for Approval of Concept: **Discussion**: This concept is not recommended for approval. The concept did not pass the evidence criterion.

Appendix A: Concept Specifications

	0030 Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure
Status	Maintenance, Original Endorsement: Aug 10, 2009, Most Recent Endorsement: Aug 10, 2009
Steward	National Committee for Quality Assurance Other organizations: N/A
Description	This is a patient-reported measure collected through the Health Outcomes Survey with two rates that address management of urinary incontinence in older adults. Discussing urinary incontinence: Percentage of patients 65 years of age and older who self-report having a urine leakage problem in the last six months and who discussed their urinary leakage problem with their health care provider. Receiving urinary incontinence treatment: The percentage of patients 65 years of age and older who self-report having a urine leakage problem in the last six months and who received treatment for their current urine leakage problem.
Type	Process
Data Source	Patient Reported Data/Survey Medicare Health Outcomes Survey
Level	Health Plan, Integrated Delivery System
Setting	Other This measure does not specify a specific setting where care must be provided.
Numerator Statement	a) Discussing Urinary Incontinence: The number of patients who reported having a problem with urine leakage in the past 6 months and indicated they discussed their urine leakage problem with their current provider. b) Receiving Urinary Incontinence Treatment: The number of patients who reported having a problem with urine leakage in the past 6 months and indicated they received treatment for their current urine leakage problem.
Numerator Details	Time Window: The measurement year (one calendar year) a) Discussing Urinary Incontinence Question 3: Have you talked to your current doctor or other health provider about your urine leakage problem? Answer="Yes" b) Receiving Urinary Incontinence Treatment Question 4:There are many ways to treat urinary incontinence including bladder training, exercises, medication and surgery. Have you received these or any other treatments for your current urine leakage problem? Answer= “Yes” Individuals with dementia and other cognitive disabilities may be unable to answer these questions. To address this limitation, the Health Outcomes Survey allows for a family member or “proxy” to fill out the survey. The survey is mailed to patients with the following instructions: “If you are unable to complete this survey, a family member or “proxy” can fill out the survey about you” At the end of the survey, the respondent is asked the following question: Q5 = Who completed this survey form? Answer = “Person to whom survey was addressed” or “Family member or relative of person to whom the survey was addressed” or “Friend of person to whom the survey was addressed” or “Professional caregiver of person to whom the survey was addressed” This information is used to determine if information from proxy respondents is systematically biased or different from patient self-reported data.
Denominator	The number of patients 65 years and older who responded to the survey indicating they had

	0030 Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure
Statement	accidentally leaked urine in the past 6 months and their urine leakage was a problem.
Denominator Details	Time Window: Measurement Year. Member choices must be as follows to be included in the denominator: Q1= Many people experience problems with urinary incontinence, the leakage of urine. In the past 6 months, have you accidentally leaked urine? Answer= "Yes" Q2= How much of a problem, if any, was the urine leakage for you? Answer= "A big problem" or "a small problem" (Note: Patients who "not a problem" are not included in the measure denominator).
Exclusions	N/A
Exclusion Details	N/A
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Copyright/ Disclaimer	© 2012 by the National Committee for Quality Assurance 1100 13th Street, NW, Suite 1000 Washington, DC 20005 N/A

	0098 Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure
Status	Maintenance, Original Endorsement: May 01, 2007, Most Recent Endorsement: May 01, 2007
Steward	National Committee for Quality Assurance Other organizations: AMA-PCPI
Description	This is a clinical performance measure which assesses whether women age 65+ were provided appropriate treatment for urinary incontinence (UI). This measure has three rates: (A) Assessment for UI: Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months. (B) Characterization of UI: Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months (C) Plan of Care for UI: Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months
Type	Process
Data Source	Administrative claims
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	This measure has three rate. The numerator for each of the rates is as follows: (A) Assessment for UI: Patients who were assessed for the presence or absence of urinary

	0098 Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure
	incontinence within 12 months (B) Characterization of UI: Patients whose urinary incontinence was characterized at least once within 12 months (C) Plan of Care for UI: Patients with a documented plan of care for urinary incontinence at least once within 12 months Urinary incontinence is defined as any involuntary leakage of urine. Characterization of urinary incontinence may include one or more the following: frequency, volume, timing, type of symptoms, and/or how bothersome to the patient Plan of care may include behavioral interventions (e.g., bladder training, pelvic floor muscle training, prompted voiding), referral to specialist, surgical treatment, reassess at follow-up visit, lifestyle interventions, addressing co-morbid factors, modification or discontinuation of medications contributing to urinary incontinence, or pharmacologic therapy.
Numerator Details	Time Window: 1x within measurement year The numerator for this measure is based on reporting CPT Category II codes. The codes for each rate numerator are as follows: (A) Assessment of UI: 1090F - Presence or absence of urinary incontinence assessed (B) Characterization of UI: 1091F - Urinary incontinence characterized (C) Plan of Care for UI: 0509F - Urinary incontinence plan of care documented
Denominator Statement	There are two denominators for the rates in this measure. (A) Assessment of UI: All female patients aged 65 years and older who visited and eligible provider in the measurement year (B&C) Characterization and Plan of Care for UI: All female patients aged 65 years and older with a diagnosis of urinary incontinence who visited an eligible provider in the measurement year.
Denominator Details	Time Window: 12 month measurement period The denominator for rate (A) Assessment of UI, is based on office visits to an eligible provider. CPT codes are used to identify female patients age 65 + with an office visit to an eligible provider. The denominator for rates (B&C) Characterization and Plan of Care for UI, is based on office visits and a documented diagnosis using ICD-9 codes. (A) Assessment of UI: CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404 (B&C) Characterization & Plan of Care: ICD-9 diagnosis codes 307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39 AND CPT service codes 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404
Exclusions	Documentation of medical reason(s) for not assessing the presence or absence of urinary incontinence within 12 months

	0098 Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure
Exclusion Details	CPT Category II code: 1090F–1P - Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Copyright/ Disclaimer	© 2012 by the National Committee for Quality Assurance 1100 13th Street, NW, Suite 1000 Washington, DC 20005 N/A

	0622 GERD - Upper Gastrointestinal Study in Adults with Alarm Symptoms
Status	Maintenance, Original Endorsement: Dec 04, 2009, Most Recent Endorsement: Dec 04, 2009
Steward	ActiveHealth Management
Description	The percentage of adult patients with gastroesophogeal reflux disease (GERD) with alarm symptoms who have had an upper gastrointestinal study.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Patient Reported Data/Survey, Electronic Clinical Data : Pharmacy We allow data from several different sources including claims, health information exchanges, provider and patient surveys, our patient health portal, and through feedback given to our nurses via telephonic engagement. All data is processed through ActiveHealth Management's clinical rule engine, CareEngine. Electronic clinical data source for pharmacy, lab, and EHR data is ActiveCareTeam (clinical workflow tool and dashboard) and MyActiveHealth (PHR). Healthcare provider survey and patient survey included as a part of clinical alerts (aka Care Considerations) feedback section. Patient self-reported data is included as a part of our patient portal (My ActiveHealth) and our disease management program (Active DM).
Level	Population : National, Population : Regional
Setting	Ambulatory Care : Clinician Office/Clinic, Home Health
Numerator Statement	Patients who have had an upper gastrointestinal study
Numerator Details	Time Window: 12 months One of the following is correct a. Evidence of at least 1 esophageal procedure, upper GI study (Upper GI radiologic exam with high density barium, with or without delayed films, eshophageal or gastric motility study, gastric emptying study,gastric analysis test, upper GI endoscopy, or upper GI series), or gastrectomy from claims or HIE in the past 12 months b. Evidence of at least 1 gastric or esophageal cancer diagnosis from claims or HIE in the past 12 months; note-cancer diagnosis implies diagnostic testing was done, and therefore completes numerator c. Presence of provider or patient feedback indicating that a GI Evaluation already implemented in the past 12 months. d. Presence of patient self-reported data confirming at least 1 EGD or Upper GI Study in past 12

	0622 GERD - Upper Gastrointestinal Study in Adults with Alarm Symptoms
	months
Denominator Statement	Patients, 18 years and older, diagnosed with GERD with alarm symptoms (e.g., dysphagia, iron deficiency anemia, weight loss)
Denominator Details	Time Window: 12 months DENOMINATOR All of the following are correct: 1. Age = 18 Years 2. One of the following is correct: a. Presence of patient self-reported data, via PHR or telephonic nurse assessment in our disease management program, confirming they have GERD and GERD warning symptoms in the past 12 months b. All of the following are correct: i. Presence of at least 2 diagnosis codes from claims or 1 diagnosis code from HIE for GERD in the past 12 months ii. One of the following: A. At least 2 diagnosis codes from claims or 1 diagnosis code from HIE for weight loss in the past 12 months B. At least 2 diagnosis codes from claims or 1 diagnosis code from HIE for dysphagia in the past 12 months C. Patient data via feedback survey or PHR indicating that they have GERD with warning symptoms in the past 12 months iii. One of the Following are correct: A. Presence of at least 1 fill for a 60 total days supply of a PUD/GERD medication in the past 12 months from claims B. Presence of at least 1 fill for a PUD/GERD medication in the past 3 months from HIE
Exclusions	Specific Exclusions: 1. Patients with a documented gastrointestinal malignancy 2. Patients with other causes of the alarm symptoms including esophageal varices, known Barrett's esophagus, or gastric restrictive procedures General Exclusions: Metastatic malignancy, chemotherapy/radiation therapy, hospice and Skilled Nursing Facility, feedback from physician indicating GI study contraindicated or not applicable.
Exclusion Details	SPECIFIC DENOMINATOR EXCLUSIONS 1. Presence of at least 2 diagnosis codes from claims or 1 diagnosis code from HIE for Barrett's esophagus in the past 24 months 2. Presence of at least 2 diagnosis codes from claims or 1 diagnosis code from HIE for esophageal varices in the past 24 months 3. Presence of at least 2 diagnosis codes from claims or 1 diagnosis code from HIE for a gastrointestinal cancer in the past 24 months 4. Presence of at least diagnosis code from claims or HIE for weight loss surgery or a gastric restrictive procedure anytime in the past
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification
Stratification	This measure is not stratified.
Copyright/	This information, including any attachments hereto, is the sole, exclusive, proprietary and

	0622 GERD - Upper Gastrointestinal Study in Adults with Alarm Symptoms
Disclaimer	confidential property of ActiveHealth Management, Inc., and is for the exclusive use of The National Quality Forum. Any use, copying, disclosure, dissemination or distribution by anyone other than the National Quality Forum is strictly prohibited.

	0635 Chronic Liver Disease - Hepatitis A Vaccination
Status	Maintenance, Original Endorsement: Dec 04, 2009, Most Recent Endorsement: Dec 04, 2009
Steward	ActiveHealth Management
Description	The percentage of adult patients with chronic liver disease who have received a hepatitis A vaccine
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Electronic Clinical Data : Laboratory, Patient Reported Data/Survey, Electronic Clinical Data : Pharmacy Claims ingested via ActiveHealth Management's rules engine, CareEngine. Electronic clinical data source for pharmacy, lab, and EHR data is ActiveCareTeam (clinical workflow tool and dashboard) and MyActiveHealth (PHR). Healthcare provider survey and patient survey included as a part of clinical alerts (aka Care Considerations) feedback section.
Level	Population : National, Population : Regional
Setting	Ambulatory Care : Clinician Office/Clinic, Home Health
Numerator Statement	Patients with chronic liver disease who have received a hepatitis A vaccine or who have been tested for immunity in the past. Keeping in consideration that providers who test for Hepatitis A immunity most likely intend to take action on the test results and that hepatitis A testing is usually communicated in the form of LOINC codes which do not indicate immunity confirmed , immunity testing is considered sufficient for completion of the numerator for this measure.
Numerator Details	Time Window: Anytime in the past One of the following: 1. At least 1 fill of Hepatitis A vaccine from claims or HIE anytime in the past 2. At least 1 Hepatitis A vaccine procedure from claims or HIE anytime in the past 3. At least 1 Hepatitis A antibody procedure from claims or HIE anytime in the past 4. At least 1 Hepatitis A Lab result from claims or HIE anytime in the past 5. Patient-reported data indicating that they received a Hepatitis A vaccine anytime in the past
Denominator Statement	All patients, ages 18 and older, diagnosed with chronic liver disease
Denominator Details	Time Window: 12 months All of the following: 1. Age >/= 18 years 2. One of the following a. One of the following i. At least 2 diagnosis codes from claims or 1 diagnosis code from HIE for Chronic Hepatitis B in the past 24 months ii. Patient self-reported data, via PHR or telephonic nurse assessment in our disease management program, confirming a diagnosis of Chronic Hepatitis B anytime in the past iii. At least 2 hepatitis B surface or E antigen or DNA Labs Result Value > 1 in the past 12

	0635 Chronic Liver Disease - Hepatitis A Vaccination
	months from claims iv. At least 2 diagnosis codes from claims for Chronic Hepatitis B anytime in the past with one of the following A. At least 1 current fill of a Hepatitis B medication from HIE B. At least 2 fills of a Hepatitis B medication from claims in the past 24 months C. At least 2 procedure codes for Interferon therapy in the past 24 months from claims b. One of the following i. At least 2 diagnosis codes from claims or 1 diagnosis code from HIE for Chronic Hepatitis C in the past 24 months ii. Patient self-reported data, via PHR or telephonic nurse assessment in our disease management program, confirming a diagnosis of Chronic Hepatitis C anytime in the past iii. At least 1 hepatitis C antibody or RNA Labs Result Value > 1 in the past 12 months iv. Patient self-reported data, via PHR or telephonic nurse assessment in our disease management program, confirming a diagnosis of Chronic Hepatitis C anytime in the past v. At least 2 diagnosis codes from claims for Chronic Hepatitis C anytime in the past with one of the following A. At least 2 fills of a Hepatitis C medication from HIE B. At least 2 fills of a Hepatitis C medication from claims in the past 24 months C. At least 2 procedure codes for Hepatitis C treatment in the past 24 months from claims D. At least 2 diagnosis codes from claims for chronic liver disease (excluding Hepatitis A) in the past 12 months
Exclusions	Patients with a previous history of viral hepatitis A. General exclusions: 1. Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months; 2. Patients who have been in a skilled nursing facility in the last 3 months (this exclusion is included to avoid holding physicians who care for patients during a transitional period, e.g. temporary SNF placement, for their ongoing care; hence, the time limitation of 3 months).
Exclusion Details	One of the following: 1. At least 1 diagnosis code for Hepatitis A infection from claims or HIE anytime in the past 2. Patient self-reported data,via PHR or telephonic nurse assessment in our disease management program, indicating that they are allergic to the Hepatitis A vaccine anytime in the past
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment necessary
Stratification	None
Copyright/ Disclaimer	This information, including any attachments hereto, is the sole, exclusive, proprietary and confidential property of ActiveHealth Management, Inc., and is for the exclusive use of The National Quality Forum. Any use, copying, disclosure, dissemination or distribution by anyone other than the National Quality Forum is strictly prohibited.

	0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients
Status	Maintenance, Original Endorsement: Jan 17, 2011, Most Recent Endorsement: Jan 17, 2011
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Society for Gastrointestinal Endoscopy (ASGE)/American Gastroenterological Association (AGA)/National Committee for Quality Assurance

	0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients
Description	Percentage of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.
Type	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Registry Not applicable. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634757781692493718-634759686421435928.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic
Numerator Statement	Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report
Numerator Details	Time Window: Once for each screening colonoscopy performed during the measurement period Patients will be counted in the numerator if there is reference in the final colonoscopy report that the appropriate follow-up interval for the next colonoscopy is at least 10 years from the date of the current colonoscopy (ie, the colonoscopy performed during the measurement period). For claims specifications, a CPT Category II code will be reported for this measure. For EHR specifications, we will use SNOMED-CT to identify the information in the final colonoscopy report. In Stage 2 of this pilot, we will submit EHR specifications and claims specifications; the combination of the two types of specifications can be used for registry reporting. The data stream for registries can be claims, EHR or manual data entry.
Denominator Statement	All patients aged 50 years and older receiving screening colonoscopy without biopsy or polypectomy
Denominator Details	Time Window: Each procedure/diagnostic study performed during 12 consecutive months The denominator of this measure includes patients at least 50 years of age who receive a screening colonoscopy during the measurement period. The denominator details will include the patient age criterion and applicable CPT, G-Codes and SNOMED-CT procedure codes for a screening colonoscopy. The procedures that will be identified include only those without biopsy or polypectomy, meaning the patient did not have any polyps removed or biopsied during the colonoscopy procedure. In Stage 2 of this pilot, we will submit EHR specifications and claims specifications.
Exclusions	Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, above average risk patient, inadequate prep)
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure 0658, exceptions may include medical reason(s) (eg, above average risk patient, inadequate prep) for not recommending at least a 10 year follow-up interval. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient

	0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients
	management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional information by data source includes: For claims specifications, a CPT Category II modifier will be reported by the physician to indicate the patient has an allowable exception for the measure. For EHR specifications, we will develop value sets for the examples provided in the measure.
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) (eg, above average risk patient, inadequate prep). If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Calculation algorithm is included in attachment 2a1.30.
Copyright/ Disclaimer	Physician Performance Measures (Measures) and related data specifications developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement ® (PCPI) and the National Committee for Quality Assurance (NCQA), pursuant to government sponsorship under Subcontract No. 6414-07-089 with Mathematica Policy Research under Contract HHSM-500-2005-000251(0004) with Centers for Medicare and Medicaid Services. These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into

	0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients
	a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA, (on behalf of the PCPI) or NCQA. Neither the AMA, NCQA, PCPI nor its members shall be responsible for any use of the Measures. THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, NCQA, the PCPI and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT ®) or other coding contained in the specifications.

	0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use
Status	Maintenance, Original Endorsement: Jan 17, 2011, Most Recent Endorsement: Jan 17, 2011
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Society for Gastrointestinal Endoscopy (ASGE)/American Gastroenterological Association (AGA)/National Committee for Quality Assurance
Description	Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp in previous colonoscopy findings who had a follow-up interval of 3 or more years since their last colonoscopy documented in the colonoscopy report
Type	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Registry N/A
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility
Numerator Statement	Patients who had an interval of 3 or more years since their last colonoscopy
Numerator Details	Time Window: Every procedure within the denominator time window. Patients will be counted in the numerator if the current colonoscopy (in the denominator was performed at least 3 years after the date of the prior colonoscopy. In Stage 2, we will submit EHR specifications and claims specifications; the combination of the 2 specifications can be used in registry reporting. The data stream for registries can be claims, EHR

	0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use
	or manual data entry. For EHR, patients will be counted based on looking back to determine if at least 3 years passed between the current and prior colonoscopies. The date of the prior colonoscopy will be searched in the EHR, and then compared to the date of the current colonoscopy (ie, colonoscopy performed during the measurement period). If the prior colonoscopy was performed at least 3 years prior to the current colonoscopy, then the patient will meet the measure. For claims data, a CPT Category II code will be reported to indicate that the interval between the current colonoscopy and the prior colonoscopy was at least 3 years.
Denominator Statement	All patients aged 18 years and older receiving a surveillance colonoscopy with a history of a prior colonic polyp in a previous colonoscopy
Denominator Details	Time Window: All patients aged 18 years and older receiving a surveillance colonoscopy with a history of a prior colonic polyp in a previous colonoscopy The denominator includes patients at least 18 years of age who have a history of colonic polyps who also received a colonoscopy during the measurement period. The denominator details will include the patient age criterion, applicable ICD-9-CM, ICD-10-CM, SNOMED-CT diagnosis codes for history of colonic polyps, and applicable CPT, G codes and SNOMED-CT codes for receiving a surveillance colonoscopy. In Stage 2, we will submit EHR specifications and claims specifications; the combination of the 2 specifications can be used in registry reporting. The data stream for registries can be claims, EHR or manual data entry.
Exclusions	Documentations of medical reason(s) for an interval of less than 3 years since the last colonoscopy (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas) OR Documentation of a system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy report was incomplete)
Exclusion Details	The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas) or system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy report was incomplete). Where examples of exceptions are included in the measure language, value sets for these examples are developed and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. Additional details by data source are as follows: For EHR: Patients will be excluded from the denominator if there is documentation of a medical or system reason for performing a colonoscopy within 3 years (less than 3 years) since the last colonoscopy • Examples of medical reasons include: the last colonoscopy was incomplete or had

	inadequate prep, there was piecemeal removal of adenomas, or the last colonoscopy found greater than 10 adenomas • Examples of system reasons include: unable to locate previous colonoscopy report, previous colonoscopy report was incomplete) Value sets for the examples included in the medical or system reasons will be developed to identify patients with allowable exceptions. For Claims: Patients will also be excluded from the denominator if there is documentation of a medical or system reason for recommending a subsequent colonoscopy within 3 years from the current colonoscopy. A CPT Category II code will be reported for patients who have an allowable exception to the measure.
Risk Adjustment	No risk adjustment or risk stratification N/A URL http://www.ama-assn.org/ama1/pub/upload/mm/370/endoscopy-ms.pdf
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. Stratification by insurance coverage (Commerical, Medicare and Medicaid) is recommended by some implementers.
Type Score	Rate/proportion
Algorithm	See sample calculation algorithm attached
Copyright/ Disclaimer	Physician Performance Measures (Measures) and related data specifications developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement ® (PCPI) and the National Committee for Quality Assurance (NCQA), pursuant to government sponsorship under Subcontract No. 6414-07-089 with Mathematica Policy Research under Contract HHSM-500-2005-000251(0004) with Centers for Medicare and Medicaid Services. These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA, (on behalf of the PCPI) or NCQA. Neither the AMA, NCQA, PCPI nor its members shall be responsible for any use of the Measures. THE MEASURES AND SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND. © 2008 American Medical Association and National Committee for Quality Assurance. All Rights Reserved. Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, NCQA, the PCPI and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT ®) or other coding contained in the specifications.

	0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use
	CPT ® contained in the Measures specifications is copyright 2007 American Medical Association. LOINC ® copyright 2004 Regenstrief Institute, Inc. SNOMED CLINICAL TERMS (SNOMED CT ®) copyright 2004 College of American Pathologists (CAP). All Rights Reserved. Use of SNOMED CT ® is only authorized within the United States.

	C 2038 Performing vaginal apical suspension (uterosacral, iliococygeus, sacrospinous or sacral colpopexy) at the time of hysterectomy to address uterovaginal prolapse
Status	New Submission
Steward	American Urogynecologic Society
Description	Percentage of female patients undergoing hysterectomy for the indication of uterovaginal prolapse in which a concomitant vaginal apical suspension (i.e.uterosacral, iliococygeus, sacrospinous or sacral colpopexy)is performed.
Type	Process
Data Source	Administrative claims, Paper Medical Records Practice Patterns Associated with Surgical Care of Pelvic Organ Prolapse: A Targeted Chart Review
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Hospital/Acute Care Facility
Numerator Statement	The number of female patients who have a concomitant vaginal apical suspension (i.e.uterosacral, iliococygeus, sacrospinous or sacral colpopexy) at the time of hysterectomy for uterovaginal prolapse.
Numerator Details	Time Window: CPT codes for uterosacral, iliococygeus, sacrospinous or sacral colpopexy
Denominator Statement	Hysterectomy, performed for the indication of uterovaginal prolapse
Denominator Details	Time Window: Hysterectomy, performed for the indication of uterovaginal prolapse as identified the ICD-9 diagnosis codes for utero/vaginal prolapse and the CPT codes for hysteretomy.
Exclusions	• Patients with a gynecologic or other pelvic malignancy noted at the time of hysterectomy • Patients undergoing a concurrent obliterative procedure (vaginectomy) • Patients undergoing excision of prolapsed cervix only (prior sub-total hysterectomy)
Exclusion Details	ICD-9 diagnosis codes for gynecologic cancers. CPT codes for vaginectomy.
Risk Adjustment	No, we do not plan to risk adjust the measure.
Stratification	No, we do not plan to stratify the measure results.
Copyright/ Disclaimer	None

	C 2049 Complete Workup for Assessment of Stress Urinary Incontinence Prior to Surgery
Status	New Submission
Steward	American Urological Association Other organizations: American Congress of Obstetricians and Gynecologists (ACOG)
Description	Percentage of female patients who had SUI surgery and who received a complete workup assessing stress urinary incontinence and for whom SUI is objecitvely demonstrated within 12 months prior to surgery
Type	Process
Data Source	Administrative claims, Paper Medical Records
Level	Clinician : Individual
Setting	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	Female patients who received the following as part of their complete workup within 12 months prior to surgery: Characterization of incontinence: focused history (questions asked of patient: duration of incontinence; number of episodes; use of protective products; i.e. "bother") focused physical exam; objective demonstration of stress incontinence; post void residual analysis; urinary analysis and urine culture, if indicated
Numerator Details	Time Window: The numerator will be calculated using CPT codes.The timeframe is 12 months. A focused physicial exam includes an abdominal exam and a pelvic exam. Objective demonstration stress incontinence includes either incontinence demonstrated on pelvic exam when the patient coughs or performs a Valsava maneuver or stress incontinence is demonstrated through urodynamic testing. Urinalysis is performed in all patients. If there is evidence of pyuria, bacteriuria or other findings suggestive of a possible urinary tract infection, then a urine culture should be obtained.
Denominator Statement	All female patients who had SUI surgery without concomitant surgery for prolapse. Patients with concomitant surgery for prolapse were excluded from the denominator because these measures are based on the AUA SUI guidelines which focused on an index patient without concomitant prolapse surgery. Prolapse surgery patients complicate the interpretation of the quality measures for SUI surgery such as characterization of prolapse symptoms, documentation of the involved compartments, and the severity of prolapse of each of the compartments as part of the physical exam. These elements are not necessary for stress incontinence patients. Prolapse patients should be excluded prior to SUI surgery to avoid potential complications.
Denominator Details	Time Window: The denominator will be calculated using CPT codes and patient characteristics, such as gender and age (adult patients). Concomitant prolapse surgery includes repair of cystocele, enterocele, rectocele or vaginal vault prolapse or hysterectomy performed due to uterine prolapse.
Exclusions	Documentation of medical reason(s) for not performing a complete workup for assessment of stress urinary incontinence (such as prolapse; cognitive impairment limiting characterization of SUI--information might be obtained via caregiver).
Exclusion Details	Exclusions will be calculated using CTP II codes and patient characteristics, such as age (adult population) and gender. Concomitant prolapse surgery includes repair of cystocele, enterocele,

	C 2049 Complete Workup for Assessment of Stress Urinary Incontinence Prior to Surgery
	rectocele or vaginal vault prolapse or hysterectomy performed due to uterine prolapse.
Risk Adjustment	N/A
Stratification	N/A
Copyright/ Disclaimer	 Physician Performance Measures (Measures) and related data specifications have been developed by the American Urological Association (AUA) and the American Congress of Obstetricians and Gynecologists (ACOG). These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. Neither AUA, ACOG, the American Medical Association (AMA), the AMA-convened Physician Consortium for Performance Improvement® (PCPI™) nor its members shall be responsible for any use of the Measures. AUA and ACOG encourage use of these Measures by other health care professionals, where appropriate.

	C 2050 Patient counseling on treatment options, including behavioral and surgical treatments prior to SUI surgery
Status	New Submission
Steward	American Urological Association Other organizations: American Congress of Obstetricians and Gynecologists (ACOG)
Description	Percentage of female patients who had SUI surgery for whom there was documentation that treatment options were discussed with the patient, including behavioral and surgical treatments, and expectations for treatment (discuss cure/dry rates)
Type	Process
Data Source	Administrative claims, Paper Medical Records
Level	Clinician : Individual
Setting	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	Female patients who had SUI surgery for whom there was documentation that treatment options were discussed with the patient, including behavioral and surgical, and expectations for treatment (discuss cure/dry rates)
Numerator Details	Time Window: The numerator will be calculated using CPT codes. The timeframe is within 12 months. Surgery includes, but is not limited to, pubovaginal and midiuretheral sling procedures, injection therapes, retropubic and laparoscopic suspensions, with at least one of these procedures being discussed. Behavioral treatment includes biofeedback, fluid restriction, pelvic floor muscle excercises, and timed voiding. Discussion on cure/dry rates should indicate that some patients are cured while others are improved. AUA SUI guidelines report cure/dry rates as follows: All suspensions at 12-23 months range from 69-82%. Slings at 12-23 months range from 74-90%. Collagen injectables at 12-23 months were approximately 48%. However, individual results can vary considerably; the surgeon should discuss his/her specific rates with the patient.

	C 2050 Patient counseling on treatment options, including behavioral and surgical treatments prior to SUI surgery
Denominator Statement	Female patients who had SUI surgery (without concomitant surgery for prolapse)
Denominator Details	Time Window: The denominator will be calculated using CPT codes and patient characteristics, such as gender and age. The timeframe is within 12 months. Concomitant surgery for prolapse includes repair of cystocele, enterocele, rectocele or vaginal vault prolapse or hysterectomy performed due to ureterine prolapse.
Exclusions	Documentation of medical reason(s) for not counseling patient (e.g. patients who had concomitant prolapse or who are severely cognitively impaired). Documentation of patient reason(s) for not counseling patient (patients who might be uncomfortable with the responsibility of making choices regarding their care).
Exclusion Details	Exclusions will be calculated using CTP codes and patient characteristics, such as gender.
Risk Adjustment	N/A
Stratification	N/A
Copyright/ Disclaimer	© 2012 American Urological Association. All Rights Reserved. Physician Performance Measures (Measures) and related data specifications have been developed by the American Urological Association (AUA) and the American Congress of Obstetricians and Gynecologists (ACOG) These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. Neither AUA, ACOG, the American Medical Association (AMA), the AMA-convened Physician Consortium for Performance Improvement® (PCPI™) nor its members shall be responsible for any use of the Measures. AUA and ACOG encourage use of these Measures by other health care professionals, where appropriate.

	C 2052 Reduction of Complications through the use of Cystoscopy during Surgery for Stress Urinary Incontinence
Status	New Submission
Steward	American Urological Association Other organizations: American Congress of Obstetricians and Gynecologists (ACOG)
Description	Percentage of SUI surgeries for which cystoscopy was used during the surgical procedure to reduce complications
Type	Process
Data Source	Administrative claims, Paper Medical Records
Level	Clinician : Individual
Setting	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	Female patients who had SUI surgery for which cystoscopy was used during the surgical procedure to reduce complications
Numerator Details	Time Window:

	C 2052 Reduction of Complications through the use of Cystoscopy during Surgery for Stress Urinary Incontinence
	The numerator will be calculated using CPT codes.
Denominator Statement	Female patients who had SUI surgeries (without concomitant surgery for prolapse)
Denominator Details	Time Window: The denominator will be calculated using CPT codes and patient characteristics, such as gender and age (adult patients). Concomitant prolapse surgery includes repair of cystocele, enterocele, rectocele or vaginal vault prolapse or hysterectomy performed due to uterine prolapse.
Exclusions	Documentation of medical reason(s) for not using cystoscopy during SUI surgery (patients for whom the use of a cystoscope may not be appropriate, such as the presence of a new cystostomy repair). The panel noted that endoscopy after a new repair should be cautiously used. Concomitant prolapse surgery is an exclusion.
Exclusion Details	Exclusions will be calculated using CPT codes and patient characteristics, such as gender and age.
Risk Adjustment	N/A
Stratification	N/A
Copyright/ Disclaimer	© 2012 American Urological Association. All Rights Reserved. Physician Performance Measures (Measures) and related data specifications have been developed by the American Urological Association (AUA) and the American Congress of Obstetricians and Gynecologists (ACOG) These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. Neither AUA, ACOG, the American Medical Association (AMA), the AMA-convened Physician Consortium for Performance Improvement® (PCPI™) nor its members shall be responsible for any use of the Measures. AUA and ACOG encourage use of these Measures by other health care professionals, where appropriate.

	C 2059 IBD preventive care: corticosteroid sparing therapy
Status	New Submission
Steward	American Gastroenterological Association Other organizations: This measure was developed via the Physician Consortium for Physician Improvement (PCPI)(R)Independent Measures Development Process. In addition to a PCPI representative there were representatives from the Crohn's and Colitis Foundation of America (CCFA) and American Society of Colon and Rectal Surgeons.
Description	Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease who have been managed by corticosteroid* greater than or equal to 10mg/day for 60 or greater consecutive days that have been prescribed corticosteroid sparing therapy in the last reporting year.
Type	Process
Data Source	Electronic Clinical Data : Registry The AGA Digestive Health Recognition Program(TM)
Level	Clinician : Individual
Setting	Ambulatory Care : Clinician Office/Clinic

	C 2059 IBD preventive care: corticosteroid sparing therapy
Numerator Statement	Patients managed with corticosteroids greater than or equal to 10mg/day for 60 or greater consecutive days AND prescribed a corticosteroid sparing therapy (e.g. thiopurines, methotrexate, or anti-TNF agents).
Numerator Details	Time Window: CPT Category II codes have been assigned for purposes of PQRS. Subsequently the AGA Digestive Health Recognition Program (TM)has been launched. In this program an online data collection form to record clinical data for each patient will be submitted to a registry. Related definition:Prednisone equivalents can be determined using the following: 1 mg of prednisone = 1 mg of prednisolone; 5 mg of cortisone; 4 mg of hydrocortisone; 0.8 mg of triamcinolone; 0.8 mg of methylprednisolone; 0.15 mg of dexamethasone; 0.15 mg of betamethasone.
Denominator Statement	All patients aged 18 years and older with a diagnosis of inflammatory bowel disease.
Denominator Details	Time Window: For PQRS: Age and ICD9 /ICD10 codes in combination with CPT Service Codes. AGA Digestive Health Recognition Program (TM): Uses an online data collection form to record age and diagnosis data for each patient (in sample) will be submitted to a registry. In the AGA Digestive Health Recognition Program (TM) because of the use of clinical data those that have not received a dose of corticosteroids greater than or equal to 10mg/day for 60 or greater consecutive days are excluded from the denominator.
Exclusions	PQRS: Documentation of medical reason(s) for not treating with corticosteroid sparing therapy (e.g., toxicity,allergy,loss of effectiveness). In the AGA Digestive Health Recognition Program (TM) because of the use of clinical data those that have not received a dose of corticosteroids greater than or equal to 10mg/day for 60 or greater consecutive days are excluded from the denominator. We have also been able to include a patient exclusion for example if the patient refuses steroid sparing therapy.
Exclusion Details	PQRS: Add a P1 modifer to the CPT Category II code that identifies that corticosteroid sparing therapy prescribed. AGA Digestive Health Recognition Program: Addressed with specfic questions in the data collection form regarding these exclusions.
Risk Adjustment	N/A
Stratification	N/A
Copyright/ Disclaimer	 Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AGA, AMA the PCPI and its members disclaim all liability for use or accuracy of any current procedural terminology (CPT®) or other coding contained in the specifications. CPT® contained in the Measure specifications is copyright 2004- 2010 American Medical Association. LOINC® is copyright 2004-2010 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms® (SNOMED CT®) copyright 2004-2010 International Health Terminology Standards Development Organisation. All Rights Reserved. Physician performance measures (measures) and related data specifications have been developed by the American Gastroenterological Association (AGA) Institute.

	C 2059 IBD preventive care: corticosteroid sparing therapy
	These performance measures are not clinical guidelines and do not establish a standard of medical care, nor have been tested for all potential applications. Neither the AGA, the American Medical Association (AMA), the Physician Consortium for Performance Improvement® (PCPI™), nor its members shall be responsible for any use of the measures. THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

	C 2063 Use of cystoscopy concurrent with prolapse repair surgery
Status	New Submission
Steward	American Urogynecologic Society
Description	Percentage of patients that undergo concurrent cystoscopy at the time of surgery for correction of anterior and/or apical vaginal prolapse to check for lower urinary tract injury.
Type	Process
Data Source	Administrative claims, Paper Medical Records Practice Patterns Associated with Surgical Care of Pelvic Organ Prolapse: A Targeted Chart Review
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Hospital/Acute Care Facility
Numerator Statement	Numerator is the number of female patients where a concurrent intraoperative cystoscopy was performed at the time of surgery for correction of anterior and/or apical vaginal prolapse to check for lower urinary tract injury..
Numerator Details	Time Window: Numerator is measured by all women undergoing any vaginal prolapse repair where a concurrent intraoperative cystoscopy was perform. The cystoscopy will be identified by CPT code(s). Any vaginal prolapse repair will be located int he patient's record using CPT codes for anterior and/or apical vaginal prolapse surgeries.
Denominator Statement	Denominator is the number of female patients undergoing any prolapse repair surgery for correction of anterior and/or apical vaginal prolapse.
Denominator Details	Time Window: Denominator is identified as the number of female patients undergoing any prolapse repair surgery for correction of anterior and/or apical vaginal prolapse and these female patients will be identified by using CPT codes for these procedures.
Exclusions	There are no exclusions from the target population.
Exclusion Details	There are no exclusions from the target population.
Risk Adjustment	We are not planning to risk adjust this measure.
Stratification	We do not plan to stratify the results.
Copyright/ Disclaimer	None

	C 2065 Gastrointestinal Hemorrhage Mortality Rate (IQI #18)
Status	New Submission
Steward	Agency for Healthcare Research and Quality Other organizations: Battelle Memorial Institute, Stanford University and the University of California-Davis
Description	Percent of discharges with an in-hospital death among cases with a principal diagnosis of gastrointestinal hemorrhage
Type	Outcome
Data Source	Administrative claims HCUP State Inpatient Databases (SID). Healthcare Cost and Utilization Project (HCUP). Agency for Healthcare Research and Quality, Rockville, MD. Data dictionary and code tables are available at http://www.qualityindicators.ahrq.gov/Downloads/Software/WinQI/V44/Software%20Instructions%20(WinQI)%20V4.4.pdf.
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Number of in-hospital deaths among cases meeting the inclusion and exclusion rules for the denominator
Numerator Details	Time Window: All discharges with a Disposition of Patient (DISP) coded as "died" (20)
Denominator Statement	All discharges, age 18 years and older, with a principal diagnosis code of gastrointestinal hemorrhage
Denominator Details	Time Window: ICD-9-CM principal diagnosis code of Gastrointestinal hemorrhage (see below for detail) Time window may be determined by the user, but is generally a calendar year. ICD-9-CM Gastrointestinal hemorrhage diagnosis codes: 4560 ESOPHAG VARICES W BLEED 5307 MALLORY-WEISS SYNDROME 53021 ULCER ESOPHAGUS W BLEED 53082 ESOPHAGEAL HEMORRHAGE 53100 AC STOMACH ULCER W HEM 53101 AC STOMAC ULC W HEM-OBST 53120 AC STOMAC ULC W HEM/PERF 53121 AC STOM ULC HEM/PERF-OBS 53140 CHR STOMACH ULC W HEM 53141 CHR STOM ULC W HEM-OBSTR 53160 CHR STOMACH ULC HEM/PERF 53161 CHR STOM ULC HEM/PERF-OB 53200 AC DUODENAL ULCER W HEM 53201 AC DUODEN ULC W HEM-OBST 53220 AC DUODEN ULC W HEM/PERF 53221 AC DUOD ULC HEM/PERF-OBS 53240 CHR DUODEN ULCER W HEM 53241 CHR DUODEN ULC HEM-OBSTR 53260 CHR DUODEN ULC HEM/PERF

	C 2065 Gastrointestinal Hemorrhage Mortality Rate (IQI #18)
	53261 CHR DUOD ULC HEM/PERF-OB 53300 AC PEPTIC ULCER W HEMORR 53301 AC PEPTIC ULC W HEM-OBST 53320 AC PEPTIC ULC W HEM/PERF 53321 AC PEPT ULC HEM/PERF-OBS 53340 CHR PEPTIC ULCER W HEM 53341 CHR PEPTIC ULC W HEM-OBS 53360 CHR PEPT ULC W HEM/PERF 53361 CHR PEPT ULC HEM/PERF-OB 53400 AC MARGINAL ULCER W HEM 53401 AC MARGIN ULC W HEM-OBST 53420 AC MARGIN ULC W HEM/PERF 53421 AC MARG ULC HEM/PERF-OBS 53440 CHR MARGINAL ULCER W HEM 53441 CHR MARGIN ULC W HEM-OBS 53460 CHR MARGIN ULC HEM/PERF 53461 CHR MARG ULC HEM/PERF-OB 53501 ACUTE GASTRITIS W HMRHG 53511 ATRPH GASTRITIS W HMRHG 53521 GSTR MCSL HYPRT W HMRG 53531 ALCHL GSTRITIS W HMRHG 53541 OTH SPF GASTRT W HMRHG 53551 GSTR/DDNTS NOS W HMRHG 53561 DUODENITIS W HMRHG 53783 ANGIO STM/DUDN W HMRHG 53784 DIEULAFOY LES,STOM&DUOD 56202 DVRTCLO SML INT W HMRHG 56203 DVRTCLI SML INT W HMRHG 56212 DVRTCLO COLON W HMRHG 56213 DVRTCLI COLON W HMRHG 5693 RECTAL & ANAL HEMORRHAGE 56985 ANGIO INTES W HMRHG 56986 DIEULAFOY LES, INTESTINE 5780 HEMATEMESIS 5781 BLOOD IN STOOL 5789 GASTROINTEST HEMORR NOS
Exclusions	Exclude cases: • transferring to another short-term hospital • MDC 14 (pregnancy, childbirth, and puerperium) • with missing discharge disposition, gender, age, quarter, year or principal diagnosis
Exclusion Details	• transferring to another short-term hospital (Disposition of Patient (DISP) coded as Transfer to Short-term Hospital (2)) • Major Diagnostic Category 14 (pregnancy, childbirth, and puerperium) - note that this exclusion is implied by the fact that the denominator is limited to patients with a principal diagnosis code

	C 2065 Gastrointestinal Hemorrhage Mortality Rate (IQI #18)
	for gastrointestinal hemorrhage, which maps to MDC 6 (digestive) • missing discharge disposition (DISP=missing) • missing gender (SEX=missing) • missing age (AGE=missing) • missing quarter (DQTR=missing) • missing year (YEAR=missing) • missing principal diagnosis (DX1=missing)
Risk Adjustment	The predicted value for each case is computed using a two-stage hierarchical model (the first stage is a logistic regression using Generalized Estimating Equations (GEE) to account for clustering of patients within hospitals; the second stage is a reliability weight). The covariates in the logistic regression include age (in 5-year age groups pooled), APR-DRG and APR-DRG Risk of Mortality subclass, MDC and transfer-in status. The reference population used in the regression is the universe of discharges for states that participate in the HCUP State Inpatient Data (SID) for the years 2008, a database consisting of 42 states and approximately 30 million adult discharges. INTERCEPT AGE 18 to 59 AGE 65+ APR-DRG '2201' (e.g., APR-DRG 220, Risk of Mortality level 1) APR-DRG '2202' (e.g., APR-DRG 220, Risk of Mortality level 2) APR-DRG '2203' (e.g., APR-DRG 220, Risk of Mortality level 3) APR-DRG '2204' (e.g., APR-DRG 220, Risk of Mortality level 4) APR-DRG '2211' APR-DRG '2212' APR-DRG '2213' APR-DRG '2214' APR-DRG '2411' to '2413' APR-DRG '2414' APR-DRG '2421' to '2423' APR-DRG '2424' APR-DRG '2441' to '2442' APR-DRG '2443' APR-DRG '2444' APR-DRG '2532' APR-DRG '2533' APR-DRG '2534' APR-DRG '2541' to '2534' APR-DRG '2544' MDC Other TRNSFER Transfer-in Detailed risk model available at http://www.qualityindicators.ahrq.gov/Downloads/Modules/IQI/V44/Risk%20Adjustment%20Tables%20IQI%204.4.pdf APR-DRG category labels at http://hcup-us.ahrq.gov/db/nation/nis/v261_aprdrg_meth_ovrview.pdf
Stratification	Not applicable

	C 2065 Gastrointestinal Hemorrhage Mortality Rate (IQI #18)
Copyright/ Disclaimer	Not applicable Not applicable

Appendix B: Project Steering Committee and NQF Staff

STEERING COMMITTEE

Andrew Baskin, MD (Co-Chair)
Aetna, Blue Bell, PA

Christopher Saigal, MD, MPH (Co-Chair)
UCLA Medical Center, Los Angeles, CA

Liliana Bordeianou, MD, MPH
Massachusetts General Hospital, Cambridge, MA

Zahid Butt, MD
Medisolv Inc., Columbia, MD

Robert Ellis
Consumers' Checkbook, Ashburn, VA

Nancy Faller, RN, MSN, PhD, CWOCN, WOCN
Turners Falls, MA

Edward Gill, MD
VCU Medical Center, Richmond, VA

Johannes Koch, MD
Virginia Mason Medical Center, Seattle WA

Jenifer Lightdale, MD, MPH
Boston Children's Hospital, Boston, MA

Richard Luetkemeyer, MD
HealthStrategy LLC, Peoria, IL

Alayne Markland, DO, MSc
University of Alabama at Birmingham, Birmingham, AL

Paul Merguerian, MS, MD
Seattle Children's Hospital, Seattle, WA

John Morton, MD, MPH, FACS
Stanford University, Stanford, CA

Anne Pelletier-Cameron, MD
University of Michigan, Ann Arbor, MI

W. Stuart Reynolds, MD, MPH
Vanderbilt University Medical Center, Nashville, TN

Philip Schoenfeld, MD
VA Ann Arbor Healthcare System, Ann Arbor, MI

Judith Tobin, PT, MBA
Centers for Medicare and Medicaid Services, Washington, DC

NQF STAFF

Helen Burstin, MD, MPH
Senior Vice President
Performance Measures

Heidi Bossley, MSN, MBA
Vice President
Performance Measures

Taroon Amin, MA, MPH
Senior Director
Performance Measures

Ashlie Wilbon, RN, MPH
Senior Project Manager
Performance Measures

Evan M. Williamson, MPH, MS
Project Analyst
Performance Measures

Appendix C: Measures Endorsed in GI/GU since March 1, 2007

GU MEASURES

NQF Number	Title	Steward
0030	Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure	National Committee for Quality Assurance
0098	Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure	National Committee for Quality Assurance
0099 (Combined with #0098)	*Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older*	*National Committee for Quality Assurance*
0100 (Combined with #0098)	*Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older*	*National Committee for Quality Assurance*
0684	Percent of Residents with a Urinary Tract Infection (Long-Stay)	Centers for Medicare and Medicaid Services
0685	Percent of Low Risk Residents Who Lose Control of Their Bowels or Bladder (Long-Stay)	Centers for Medicare and Medicaid Services
0686	Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long-Stay)	Centers for Medicare and Medicaid Services

GI MEASURES

0034	Colorectal Cancer Screening	National Committee for Quality Assurance
0223	Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	American College of Surgeons
0225	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer	American College of Surgeons
0392	Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
0460	Risk-Adjusted Morbidity and Mortality for Esophagectomy for Cancer	The Society of Thoracic Surgeons
0572	Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy	Health Benchmarks-IMS Health
0622	GERD - Upper Gastrointestinal Study in Adults with Alarm Symptoms	ActiveHealth Management
0635	Chronic Liver Disease - Hepatitis A Vaccination	ActiveHealth Management
0658 *(Time Limited)*	Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
0659 *(Time Limited)*	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
0727	Gastroenteritis Admission Rate (pediatric)	Agency for Healthcare Research and Quality
1617	Patients Treated with an Opioid who are Given a Bowel Regimen	RAND Corporation
1854	Barrett´s Esophagus	College of American Pathologists

Appendix D: Related Concepts & Measures

Comparison of NQF #0635 and NQF #0399

	0635 Chronic Liver Disease - Hepatitis A Vaccination	0399 Paired Measure: Hepatitis C: Hepatitis A Vaccination (paired with 0400) (Under review in the Infection Disease Project, 2012)
Steward	ActiveHealth Management	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Description	The percentage of adult patients with chronic liver disease who have received a hepatitis A vaccine	Percentage of patients aged 18 years and older with a diagnosis of hepatitis C who have received at least one injection of hepatitis A vaccine, or who have documented immunity to hepatitis A
Type	Process	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Electronic Clinical Data : Laboratory, Patient Reported Data/Survey, Electronic Clinical Data : Pharmacy Claims ingested via ActiveHealth Management's rules engine, CareEngine. Electronic clinical data source for pharmacy, lab, and EHR data is ActiveCareTeam (clinical workflow tool and dashboard) and MyActiveHealth (PHR). Healthcare provider survey and patient survey included as a part of clinical alerts (aka Care Considerations) feedback section.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Registry Not Applicable
Level	Population : National, Population : Regional	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic, Home Health	Ambulatory Care : Clinician Office/Clinic, Other, Ambulatory Care : Urgent Care Hospital Outpatient Clinic
Numerator Statement	Patients with chronic liver disease who have received a hepatitis A vaccine or who have been tested for immunity in the past. Keeping in consideration that providers who test for Hepatitis A immunity most likely intend to take action on the test results and that hepatitis A testing is usually communicated in the form of LOINC codes which do not indicate immunity confirmed , immunity testing	Patients who have received at least one injection of hepatitis A vaccine, or who have documented immunity to Hepatitis A

	0635 Chronic Liver Disease - Hepatitis A Vaccination	0399 Paired Measure: Hepatitis C: Hepatitis A Vaccination (paired with 0400) (Under review in the Infection Disease Project, 2012)
	is considered sufficient for completion of the numerator for this measure.	
Numerator Details	**Time Window:** Anytime in the past One of the following: 1. At least 1 fill of Hepatitis A vaccine from claims or HIE anytime in the past 2. At least 1 Hepatitis A vaccine procedure from claims or HIE anytime in the past 3. At least 1 Hepatitis A antibody procedure from claims or HIE anytime in the past 4. At least 1 Hepatitis A Lab result from claims or HIE anytime in the past 5. Patient-reported data indicating that they received a Hepatitis A vaccine anytime in the past	**Time Window:** Once during the measurement period Definition: *Received includes documentation that a patient received at least one injection of hepatitis A vaccine from another provider EHR Specifications: eMeasure developed – see attached Claims Specifications: CPT Category II code (in development): 4148F – Hepatitis A vaccine injection administered or previously received OR CPT Category II code: 3215F – Patient has documented immunity to Hepatitis A
Denominator Statement	All patients, ages 18 and older, diagnosed with chronic liver disease	All patients aged 18 years and older with a diagnosis of hepatitis C
Denominator Details	**Time Window:** 12 months All of the following: 1. Age >/= 18 years 2. One of the following a. One of the following i. At least 2 diagnosis codes from claims or 1 diagnosis code from HIE for Chronic Hepatitis B in the past 24 months ii. Patient self-reported data, via PHR or telephonic nurse assessment in our disease management program, confirming a diagnosis of Chronic Hepatitis B anytime in the past iii. At least 2 hepatitis B surface or E antigen or DNA Labs	**Time Window:** 12 consecutive months EHR Specifications: eMeasure developed – see attached Claims Specifications: ICD-9-CM diagnosis codes: 070.51, 070.54, 070.70 AND CPT Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

	0635 Chronic Liver Disease - Hepatitis A Vaccination	0399 Paired Measure: Hepatitis C: Hepatitis A Vaccination (paired with 0400) (Under review in the Infection Disease Project, 2012)
	Result Value > 1 in the past 12 months from claims iv. At least 2 diagnosis codes from claims for Chronic Hepatitis B anytime in the past with one of the following A. At least 1 current fill of a Hepatitis B medication from HIE B. At least 2 fills of a Hepatitis B medication from claims in the past 24 months C. At least 2 procedure codes for Interferon therapy in the past 24 months from claims b. One of the following i. At least 2 diagnosis codes from claims or 1 diagnosis code from HIE for Chronic Hepatitis C in the past 24 months ii. Patient self-reported data, via PHR or telephonic nurse assessment in our disease management program, confirming a diagnosis of Chronic Hepatitis C anytime in the past iii. At least 1 hepatitis C antibody or RNA Labs Result Value > 1 in the past 12 months iv. Patient self-reported data, via PHR or telephonic nurse assessment in our disease management program, confirming a diagnosis of Chronic Hepatitis C anytime in the past v. At least 2 diagnosis codes from claims for Chronic Hepatitis C anytime in the past with one of the following A. At least 2 fills of a Hepatitis C medication from HIE B. At least 2 fills of a Hepatitis C medication from claims in the past 24 months C. At least 2 procedure codes for Hepatitis C treatment in the past 24 months from claims D. At least 2 diagnosis codes from claims for chronic liver disease (excluding Hepatitis A) in the past 12 months	
Exclusions	Patients with a previous history of viral hepatitis A. General exclusions: 1. Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6	Documentation of medical reason(s) for not receiving at least one injection of hepatitis A vaccine Documentation of patient reason(s) for not receiving at least one injection

	0635 Chronic Liver Disease - Hepatitis A Vaccination	0399 Paired Measure: Hepatitis C: Hepatitis A Vaccination (paired with 0400) (Under review in the Infection Disease Project, 2012)
	months; 2. Patients who have been in a skilled nursing facility in the last 3 months (this exclusion is included to avoid holding physicians who care for patients during a transitional period, e.g. temporary SNF placement, for their ongoing care; hence, the time limitation of 3 months).	of hepatitis A vaccine
Exclusion Details	One of the following: 1. At least 1 diagnosis code for Hepatitis A infection from claims or HIE anytime in the past 2. Patient self-reported data,via PHR or telephonic nurse assessment in our disease management program, indicating that they are allergic to the Hepatitis A vaccine anytime in the past	The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) or patient reason(s) for not receiving at least one injection of hepatitis A vaccine. Where examples of exceptions are included in the measure language, value sets for these examples are developed and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. Additional details by data source are as follows: EHR Specifications: eMeasure developed – see attached Claims Specifications: Report one of the following CPT Category II codes: 4148F-1P: Documentation of medical reason(s) for not administering at least one injection of hepatitis A vaccine 4148F-2P: Documentation of patient reason(s) for not administering at least one injection of hepatitis A vaccine
Risk	No risk adjustment or risk stratification	No risk adjustment or risk stratification

	0635 Chronic Liver Disease - Hepatitis A Vaccination	0399 Paired Measure: Hepatitis C: Hepatitis A Vaccination (paired with 0400) (Under review in the Infection Disease Project, 2012)
Adjustment	No risk adjustment necessary	None
Stratification	None	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score		Rate/proportion better quality = higher score
Algorithm		To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator when exceptions have been specified [for this measure: medical reason(s) or patient reason(s)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not

	0635 Chronic Liver Disease - Hepatitis A Vaccination	0399 Paired Measure: Hepatitis C: Hepatitis A Vaccination (paired with 0400) (Under review in the Infection Disease Project, 2012)
		present, this case represents a quality failure. Calculation algorithm is included in e-measure which was emailed to NQF staff.
Submission items	**5.1 Identified measures:** 0399 : Paired Measure: Hepatitis C: Hepatitis A Vaccination (paired with 0400) **5a.1 Are specs completely harmonized?** No **5a.2 If not completely harmonized, identify difference, rationale, impact:** While our measure includes adults with chronic liver disease in the denominator, measure 0399 includes only those with hepatitis C. **5b.1 If competing, why superior or rationale for additive value:** While our measure includes adults with chronic liver disease in the denominator, measure 0399 includes only those with hepatitis C. We feel that our measure is more encompassing of and brings attention to all of those individuals who should receive a hepatitis A vaccine. We have not yet discussed with the developers of measure 0399 to see if the endorsed measures can be combined and expanded.	**5.1 Identified measures:** 0635 : Chronic Liver Disease - Hepatitis A Vaccination **5a.1 Are specs completely harmonized?** No **5a.2 If not completely harmonized, identify difference, rationale, impact:** Our measure focuses on the provision of the hepatitis A vaccine to patients with Hepatitis C and is therefore related to measure 0635. Our measure appropriately accounts for either receipt of the vaccine or documented immunity whereas measure 0635 seems to be more narrowly focused on the receipt of the vaccine within the measurement year. Additionally, we have developed and will maintain specifications for multiple data sources for the measure, including Electronic Health Records (EHRs) and Claims-Based Reporting. Our specifications for EHRs are developed in accordance with the terminology standards (eg, SNOMED, RxNorm, LOINC) named in the Meaningful Use Program (CMS EHR Incentive Program). Measure 0584 has been specified for use with clinically enriched administrative data which is significantly more limiting in that it would only apply to groups/settings with access to that type of information (eg, laboratory testing data). **5b.1 If competing, why superior or rationale for additive value:**

Comparison of NQF #0658 and NQF #0659

	0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Description	Percentage of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.	Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp in previous colonoscopy findings who had a follow-up interval of 3 or more years since their last colonoscopy documented in the colonoscopy report
Type	Process	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Registry Not applicable. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634757781692493718-634759686421435928.pdf	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Registry N/A
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility
Numerator Statement	Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report	Patients who had an interval of 3 or more years since their last colonoscopy
Numerator Details	Time Window: Once for each screening colonoscopy performed during the measurement period Patients will be counted in the numerator if there is reference in the final colonoscopy report that the appropriate follow-up interval for the next colonoscopy is at least 10 years from the date of the current colonoscopy (ie, the colonoscopy performed during the measurement	Time Window: Every procedure within the denominator time window. Patients will be counted in the numerator if the current colonoscopy (in the denominator was performed at least 3 years after the date of the prior colonoscopy. In Stage 2, we will submit EHR specifications and claims specifications;

	0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use
	period). For claims specifications, a CPT Category II code will be reported for this measure. For EHR specifications, we will use SNOMED-CT to identify the information in the final colonoscopy report. In Stage 2 of this pilot, we will submit EHR specifications and claims specifications; the combination of the two types of specifications can be used for registry reporting. The data stream for registries can be claims, EHR or manual data entry.	the combination of the 2 specifications can be used in registry reporting. The data stream for registries can be claims, EHR or manual data entry. For EHR, patients will be counted based on looking back to determine if at least 3 years passed between the current and prior colonoscopies. The date of the prior colonoscopy will be searched in the EHR, and then compared to the date of the current colonoscopy (ie, colonoscopy performed during the measurement period). If the prior colonoscopy was performed at least 3 years prior to the current colonoscopy, then the patient will meet the measure. For claims data, a CPT Category II code will be reported to indicate that the interval between the current colonoscopy and the prior colonoscopy was at least 3 years.
Denominator Statement	All patients aged 50 years and older receiving screening colonoscopy without biopsy or polypectomy	All patients aged 18 years and older receiving a surveillance colonoscopy with a history of a prior colonic polyp in a previous colonoscopy
Denominator Details	Time Window: Each procedure/diagnostic study performed during 12 consecutive months The denominator of this measure includes patients at least 50 years of age who receive a screening colonoscopy during the measurement period. The denominator details will include the patient age criterion and applicable CPT, G-Codes and SNOMED-CT procedure codes for a screening colonoscopy. The procedures that will be identified include only those without biopsy or polypectomy, meaning the patient did not have any polyps removed or biopsied during the colonoscopy procedure. In Stage 2 of this pilot, we will submit EHR specifications and claims specifications.	Time Window: All patients aged 18 years and older receiving a surveillance colonoscopy with a history of a prior colonic polyp in a previous colonoscopy The denominator includes patients at least 18 years of age who have a history of colonic polyps who also received a colonoscopy during the measurement period. The denominator details will include the patient age criterion, applicable ICD-9-CM, ICD-10-CM, SNOMED-CT diagnosis codes for history of colonic polyps, and applicable CPT, G codes and SNOMED-CT codes for receiving a surveillance colonoscopy. In Stage 2, we will submit EHR specifications and claims specifications; the combination of the 2 specifications can be used in registry reporting. The data stream for registries can be claims, EHR or manual data entry.

	0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use
Exclusions	Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, above average risk patient, inadequate prep)	Documentations of medical reason(s) for an interval of less than 3 years since the last colonoscopy (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas) OR Documentation of a system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy report was incomplete)
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure 0658, exceptions may include medical reason(s) (eg, above average risk patient, inadequate prep) for not recommending at least a 10 year follow-up interval. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional information by data source includes: For claims specifications, a CPT Category II modifier will be reported by the physician to indicate the patient has an allowable exception for the measure.	The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas) or system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy report was incomplete). Where examples of exceptions are included in the measure language, value sets for these examples are developed and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. Additional details by data source are as follows: For EHR: Patients will be excluded from the denominator if there is

	0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use
	For EHR specifications, we will develop value sets for the examples provided in the measure.	documentation of a medical or system reason for performing a colonoscopy within 3 years (less than 3 years) since the last colonoscopy • Examples of medical reasons include: the last colonoscopy was incomplete or had inadequate prep, there was piecemeal removal of adenomas, or the last colonoscopy found greater than 10 adenomas • Examples of system reasons include: unable to locate previous colonoscopy report, previous colonoscopy report was incomplete) Value sets for the examples included in the medical or system reasons will be developed to identify patients with allowable exceptions. For Claims: Patients will also be excluded from the denominator if there is documentation of a medical or system reason for recommending a subsequent colonoscopy within 3 years from the current colonoscopy. A CPT Category II code will be reported for patients who have an allowable exception to the measure.
Risk Adjustment	No risk adjustment or risk stratification Not applicable.	No risk adjustment or risk stratification N/A URL http://www.ama-assn.org/ama1/pub/upload/mm/370/endoscopy-ms.pdf
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. Stratification by insurance coverage (Commerical, Medicare and Medicaid) is recommended by some implementers.
Type Score	Rate/proportion better quality = higher score	Rate/proportion
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is	See sample calculation algorithm attached

	0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use
	designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) (eg, above average risk patient, inadequate prep). If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Calculation algorithm is included in attachment 2a1.30.	
Submission items	**5.1 Identified measures:** 0572 : Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy 0659 : Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use ACP-018-10 : Endoscopy/Polyp Surveillance: Comprehensive Colonoscopy Documentation 0034 : Colorectal Cancer Screening	**5.1 Identified measures:** 0034 : Colorectal Cancer Screening 0658 : Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients ACP-018-10 : Endoscopy/Polyp Surveillance: Comprehensive Colonoscopy Documentation 0392 : Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with

	0658 Endoscopy/Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	0659 Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use
	0392 : Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade **5a.1 Are specs completely harmonized?** No **5a.2 If not completely harmonized, identify difference, rationale, impact:** The list of measures above, includes several different populations and capture different elements in the numerator. None of them are aiming to capture the same information as measure 0658. Measures 0572, ACP-018-10, and 0392 actually aim to capture specific elements within the colonoscopy report or pathology report (after colon/rectum resection). Measure 0034 has an entirely different patient population, as it captures patients ages 51-75 only. Measure 0659 focuses on a different patient population, as the patients in 0659 have had a history of a prior colonic polyp in previous colonoscopy findings. The patient population in measure 0659 has a different follow up interval recommendation, according to evidence based guidelines. **5b.1 If competing, why superior or rationale for additive value:** There are no competing measures.	histologic grade 0572 : Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy **5a.1 Are specs completely harmonized?** No **5a.2 If not completely harmonized, identify difference, rationale, impact:** The list of measures above, includes several different populations and capture different elements in the numerator. None of them are aiming to capture the same information as measure 0658. Measures 0572, ACP-018-10, and 0392 actually aim to capture specific elements within the colonoscopy report or pathology report (after colon/rectum resection). Measure 0034 has an entirely different patient population, as it captures patients ages 51-75 only. Measure 0659 focuses on a different patient population than measure 0658, as the patients in 0659 have had a history of a prior colonic polyp in previous colonoscopy findings. The patient population in measure 0658 has a different follow up interval recommendation, according to evidence based guidelines. **5b.1 If competing, why superior or rationale for additive value:** There are no competing measures.

Comparison of NQF #0030 and NQF #0098

	0030 Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure	0098 Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure
Steward	National Committee for Quality Assurance	National Committee for Quality Assurance
Description	This is a patient-reported measure collected through the Health Outcomes Survey with two rates that address management of urinary incontinence in older adults. Discussing urinary incontinence: Percentage of patients 65 years of age and older who self-report having a urine leakage problem in the last six months and who discussed their urinary leakage problem with their health care provider. Receiving urinary incontinence treatment: The percentage of patients 65 years of age and older who self-report having a urine leakage problem in the last six months and who received treatment for their current urine leakage problem.	This is a clinical performance measure which assesses whether women age 65+ were provided appropriate treatment for urinary incontinence (UI). This measure has three rates: (A)Assessment for UI: Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months. (B)Characterization of UI: Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months (C)Plan of Care for UI: Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months
Type	Process	Process
Data Source	Patient Reported Data/Survey Medicare Health Outcomes Survey	Administrative claims
Level	Health Plan, Integrated Delivery System	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Other This measure does not specify a specific setting where care must be provided.	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	a) Discussing Urinary Incontinence: The number of patients who reported having a problem with urine leakage in the past 6 months and indicated they discussed their urine leakage problem with their current provider. b) Receiving Urinary Incontinence Treatment: The number of patients who reported having a problem with urine leakage in the past 6 months and indicated they received treatment for their current urine leakage problem.	This measure has three rate. The numerator for each of the rates is as follows: (A) Assessment for UI: Patients who were assessed for the presence or absence of urinary incontinence within 12 months (B) Characterization of UI: Patients whose urinary incontinence was characterized at least once within 12 months (C) Plan of Care for UI: Patients with a documented plan of care for urinary incontinence at least once within 12 months Urinary incontinence is defined as any involuntary leakage of urine.

	0030 Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure	0098 Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure
		Characterization of urinary incontinence may include one or more the following: frequency, volume, timing, type of symptoms, and/or how bothersome to the patient Plan of care may include behavioral interventions (e.g., bladder training, pelvic floor muscle training, prompted voiding), referral to specialist, surgical treatment, reassess at follow-up visit, lifestyle interventions, addressing co-morbid factors, modification or discontinuation of medications contributing to urinary incontinence, or pharmacologic therapy.
Numerator Details	**Time Window:** The measurement year (one calendar year) a) Discussing Urinary Incontinence Question 3: Have you talked to your current doctor or other health provider about your urine leakage problem? Answer="Yes" b) Receiving Urinary Incontinence Treatment Question 4:There are many ways to treat urinary incontinence including bladder training, exercises, medication and surgery. Have you received these or any other treatments for your current urine leakage problem? Answer= "Yes" Individuals with dementia and other cognitive disabilities may be unable to answer these questions. To address this limitation, the Health Outcomes Survey allows for a family member or "proxy" to fill out the survey. The survey is mailed to patients with the following instructions: "If you are unable to complete this survey, a family member or "proxy" can fill out the survey about you" At the end of the survey, the respondent is asked the following question: Q5 = Who completed this survey form? Answer = "Person to whom survey was addressed" or "Family member or relative of person to whom the survey was addressed" or "Friend of	**Time Window:** 1x within measurement year The numerator for this measure is based on reporting CPT Category II codes. The codes for each rate numerator are as follows: (A) Assessment of UI: 1090F - Presence or absence of urinary incontinence assessed (B) Characterization of UI: 1091F - Urinary incontinence characterized (C) Plan of Care for UI: 0509F - Urinary incontinence plan of care documented

	0030 Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure	0098 Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure
	person to whom the survey was addressed" or "Professional caregiver of person to whom the survey was addressed" This information is used to determine if information from proxy respondents is systematically biased or different from patient self-reported data.	
Denominator Statement	The number of patients 65 years and older who responded to the survey indicating they had accidentally leaked urine in the past 6 months and their urine leakage was a problem.	There are two denominators for the rates in this measure. (A) Assessment of UI: All female patients aged 65 years and older who visited and eligible provider in the measurement year (B&C) Characterization and Plan of Care for UI: All female patients aged 65 years and older with a diagnosis of urinary incontinence who visited an eligible provider in the measurement year.
Denominator Details	**Time Window:** Measurement Year. Member choices must be as follows to be included in the denominator: Q1= Many people experience problems with urinary incontinence, the leakage of urine. In the past 6 months, have you accidentally leaked urine? Answer= "Yes" Q2= How much of a problem, if any, was the urine leakage for you? Answer= "A big problem" or "a small problem" (Note: Patients who "not a problem" are not included in the measure denominator).	**Time Window:** 12 month measurement period The denominator for rate (A) Assessment of UI, is based on office visits to an eligible provider. CPT codes are used to identify female patients age 65 + with an office visit to an eligible provider. The denominator for rates (B&C) Characterization and Plan of Care for UI, is based on office visits and a documented diagnosis using ICD-9 codes. (A) Assessment of UI: CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404 (B&C) Characterization & Plan of Care: ICD-9 diagnosis codes 307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39 AND CPT service codes

	0030 Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure	0098 Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure
		99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404
Exclusions	N/A	Documentation of medical reason(s) for not assessing the presence or absence of urinary incontinence within 12 months
Exclusion Details	N/A	CPT Category II code: 1090F–1P - Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence
Risk Adjustment	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification N/A
Submission items	**5.1 Identified measures:** 0098 : Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure **5a.1 Are specs completely harmonized?** Yes **5a.2 If not completely harmonized, identify difference, rationale, impact:** UI is defined in both measures as involuntary or accidental leakage of urine. Treatment options for UI across both measures is defined as any of the following: bladder training, pelvic floor muscle training (exercises), surgical treatment (surgery), pharmacologic therapy (medication). **5b.1 If competing, why superior or rationale for additive value:** Measure 0030 assesses whether the patient believes their urinary incontinence was discussed and treated. This information complements the clinical measure (0098) which assess documentation of management of urinary incontinence in the medical record. Both measures are necessary to allow for continued measurement of this important quality gap at different levels of accountability and using	**5.1 Identified measures:** 0030 : Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure **5a.1 Are specs completely harmonized?** Yes **5a.2 If not completely harmonized, identify difference, rationale, impact:** See 5b.1. for answer. **5b.1 If competing, why superior or rationale for additive value:** Answer for 5a.2. UI is defined in both measures as involuntary or accidental leakage of urine.Treatment options for UI across both measures is defined as any of the following: bladder training, pelvic floor muscle training (exercises), surgical treatment (surgery), pharmacologic therapy

	0030 Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure	0098 Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure
	different complimentary data sources. Measure 0098 uses administrative claims coding to determine if UI processes of care (screening, characterization and plan of care) are documented in the medical record for patients who have an in-person visit with an eligible provider. This measure uses codes specifically designed for quality measurement and measures care at the individual provider level. This measure provides detailed information about specific processes of care being provided during a visit with an eligible provider. Unlike measure 0030 it is not susceptible to recall bias and can provide more detailed information. However, this measure has several limitation: (1) documented processes in a medical record are one-sided – they only reflect the provider's point of view and do not include the patient's perspective, (2) the codes used for this measure are infrequently reported by providers and this measure excludes individuals who did not see an eligible provider in the previous year and therefore excludes care that may be provided outside of the clinician office such as in the community setting. Measure 0030 uses patient reported information to determine if patients in a health plan received UI processes of care (discuss and treatment). This measure captures the patient perception of care provision which complements the provider point-of-view documented in the medical record. Unlike measures 0098, this measure is not reliant on administrative codes being reported and can be applied to a population of patients regardless of whether they visited an eligible provider in the previous year.	(medication). There are several treatment options of UI which are included in measures 0098 which are not included in 0030 because they could not be described in a way which was easy for patients to recall and self-report: prompted voiding, lifestyle interventions, addressing co-morbid factors, modification or discontinuation of medications contributing to urinary incontinence. There are two treatment options which are specific to measure 0098 which are not included in 0030 because they refer to a transfer of care to another provider ot point in time: referral to specialist and reassess at follow-up visit. Measure 0098 focuses exclusively on women, whereas 0030 refers to all patients. Since women are more likely to experience UI, 0098 was developed to specifically target the care provided to women. The panel of experts who developed 0098 felt the benefits of measurement would be highest for women. Answer for 5b.1 Measure 0098 assesses whether there is documentation in the medical record that older women were assessed for UI, and whether there is documentation in the medical record that those women identified as having UI had their UI characterized and were provided a plan of care to manage their UI. This information complements the survey-based measure (0030) which assess whether patients who experience problems with UI report discussing UI with their health care provider and receiving treatment for their UI. Both measures are necessary to allow for continued measurement of this important quality gap at different levels of accountability and using different complimentary data sources. Measure 0098 uses administrative claims coding to determine if UI processes of care (screening, characterization and plan of care) are documented in the medical record for patients who have an in-person visit with an eligible provider. This measure uses codes specifically

	0030 Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure	0098 Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure
		designed for quality measurement and measures care at the individual provider level. This measure provides detailed information about specific processes of care being provided during a visit with an eligible provider. Unlike measure 0030 it is not susceptible to recall bias and can provide more detailed information. However, this measure has several limitation: (1) documented processes in a medical record are one-sided – they only reflect the provider's point of view and do not include the patient's perspective, (2) the codes used for this measure are infrequently reported by providers and (3) this measure excludes individuals who did not see an eligible provider in the previous year and therefore excludes care that may be provided outside of the clinician office such as in the community setting. Measure 0030 uses patient reported information to determine if patients in a health plan received UI processes of care (discuss and treatment). This measure captures the patient perception of care provision which complements the provider point-of-view documented in the medical record. Unlike measure 0098 this measure is not reliant on administrative codes being reported and can be applied to a population of patients regardless of whether they visited an eligible provider in the previous year.

Comparison of NQF C2049 and NQF C2050

	C 2049 Complete Workup for Assessment of Stress Urinary Incontinence Prior to Surgery	C 2050 Patient counseling on treatment options, including behavioral and surgical treatments prior to SUI surgery
Steward	American Urological Association	American Urological Association
Description	Percentage of female patients who had SUI surgery and who received a complete workup assessing stress urinary incontinence and for whom SUI is objecitvely demonstrated within 12 months prior to surgery	Percentage of female patients who had SUI surgery for whom there was documentation that treatment options were discussed with the patient, including behavioral and surgical treatments, and expectations for treatment (discuss cure/dry rates)

	C 2049 Complete Workup for Assessment of Stress Urinary Incontinence Prior to Surgery	C 2050 Patient counseling on treatment options, including behavioral and surgical treatments prior to SUI surgery
Type	Process	Process
Data Source	Administrative claims, Paper Medical Records	Administrative claims, Paper Medical Records
Level	Clinician : Individual	Clinician : Individual
Setting	Ambulatory Care : Clinician Office/Clinic	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	Female patients who received the following as part of their complete workup within 12 months prior to surgery: Characterization of incontinence: focused history (questions asked of patient: duration of incontinence; number of episodes; use of protective products; i.e. "bother") focused physical exam; objective demonstration of stress incontinence; post void residual analysis; urinary analysis and urine culture, if indicated	Female patients who had SUI surgery for whom there was documentation that treatment options were discussed with the patient, including behavioral and surgical, and expectations for treatment (discuss cure/dry rates)
Numerator Details	**Time Window:** The numerator will be calculated using CPT codes.The timeframe is 12 months. A focused physicial exam includes an abdominal exam and a pelvic exam. Objective demonstration stress incontinence includes either incontinence demonstrated on pelvic exam when the patient coughs or performs a Valsava maneuver or stress incontinence is demonstrated through urodynamic testing. Urinalysis is performed in all patients. If there is evidence of pyuria, bacteriuria or other findings suggestive of a possible urinary tract infection, then a urine culture should be obtained.	**Time Window:** The numerator will be calculated using CPT codes. The timeframe is within 12 months. Surgery includes, but is not limited to, pubovaginal and midureteral sling procedures, injection therapes, retropubic and laparoscopic suspensions, with at least one of these procedures being discussed. Behavioral treatment includes biofeedback, fluid restriction, pelvic floor muscle excercises, and timed voiding. Discussion on cure/dry rates should indicate that some patients are cured while others are improved. AUA SUI guidelines report cure/dry rates as follows: All suspensions at 12-23 months range from 69-82%. Slings at 12-23 months range from 74-90%. Collagen injectables at 12-23 months were approximately 48%. However, individual results can vary considerably; the surgeon should discuss his/her specific rates with the patient.
Denominator Statement	All female patients who had SUI surgery without concomitant surgery for prolapse. Patients with concomitant surgery for prolapse were excluded from	Female patients who had SUI surgery (without concomitant surgery for prolapse)

	C 2049 Complete Workup for Assessment of Stress Urinary Incontinence Prior to Surgery	C 2050 Patient counseling on treatment options, including behavioral and surgical treatments prior to SUI surgery
	the denominator because these measures are based on the AUA SUI guidelines which focused on an index patient without concomitant prolapse surgery. Prolapse surgery patients complicate the interpretation of the quality measures for SUI surgery such as characterization of prolapse symptoms, documentation of the involved compartments, and the severity of prolapse of each of the compartments as part of the physical exam. These elements are not necessary for stress incontinence patients. Prolapse patients should be excluded prior to SUI surgery to avoid potential complications.	
Denominator Details	**Time Window:** The denominator will be calculated using CPT codes and patient characteristics, such as gender and age (adult patients). Concomitant prolapse surgery includes repair of cystocele, enterocele, rectocele or vaginal vault prolapse or hysterectomy performed due to uterine prolapse.	**Time Window:** The denominator will be calculated using CPT codes and patient characteristics, such as gender and age. The timeframe is within 12 months. Concomitant surgery for prolapse includes repair of cystocele, enterocele, rectocele or vaginal vault prolapse or hysterectomy performed due to ureterine prolapse.
Exclusions	Documentation of medical reason(s) for not performing a complete workup for assessment of stress urinary incontinence (such as prolapse; cognitive impairment limiting characterization of SUI--information might be obtained via caregiver).	Documentation of medical reason(s) for not counseling patient (e.g. patients who had concomitant prolapse or who are severely cognitively impaired). Documentation of patient reason(s) for not counseling patient (patients who might be uncomfortable with the responsibility of making choices regarding their care).
Exclusion Details	Exclusions will be calculated using CTP II codes and patient characteristics, such as age (adult population) and gender. Concomitant prolapse surgery includes repair of cystocele, enterocele, rectocele or vaginal vault prolapse or hysterectomy performed due to uterine prolapse.	Exclusions will be calculated using CTP codes and patient characteristics, such as gender.
Risk Adjustment	N/A	N/A
Submission items	**5.1 Identified measures:** 0030 : Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure 0098 : Urinary Incontinence: Assessment, Characterization, and Plan	**5.1 Identified measures:** 0030 : Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure 0100 : Urinary Incontinence: Plan of Care for Urinary Incontinence in

	C 2049 Complete Workup for Assessment of Stress Urinary Incontinence Prior to Surgery	C 2050 Patient counseling on treatment options, including behavioral and surgical treatments prior to SUI surgery
	of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure 0099 : Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older **5a.1 Are specs completely harmonized?** **5a.2 If not completely harmonized, identify difference, rationale, impact:** As a rule, AUA/ACOG seek to harmonize proposed measures with those currently in use for the same topics. For example, the first of the proposed measures "Complete Workup for Assessment of Stress Urinary Incontinence" describes procedures consistent with common standard practices. In developing the proposed set of measures, extant performance measures were considered and kept in mind but were of limited usefulness because they were designed to apply to urinary incontinence in general and to women over 65 years of age. In contrast, we required measures that focused on the surgical intervention for SUI in particular and included women under 65 year of age who constitute the majority of those affected by SUI. **5b.1 If competing, why superior or rationale for additive value:**	Women Aged 65 Years and Older **5a.1 Are specs completely harmonized?** No **5a.2 If not completely harmonized, identify difference, rationale, impact:** As a rule, AUA/ACOG seek to harmonize proposed measures with those currently in use for the same topics. For example, the first of the proposed measures "Complete Workup for Assessment of Stress Urinary Incontinence" describes procedures consistent with common standard practices. In developing the proposed set of measures, extant performance measures were considered and kept in mind but were of limited usefulness because they were designed to apply to urinary incontinence in general and to women over 65 years of age. In contrast, we required measures that focused on the surgical intervention for SUI in particular and included women under 65 year of age who constitute the majority of those affected by SUI. Other existing endorsed measures focus on screening of patients in a primary care population. However, this measure set is limited to patients undergoing surgery. **5b.1 If competing, why superior or rationale for additive value:**

Comparison of NQF C 2052 and NQF C 2063

	C 2052 Reduction of Complications through the use of Cystoscopy during Surgery for Stress Urinary Incontinence	C 2063 Use of cystoscopy concurrent with prolapse repair surgery
Steward	American Urological Association	American Urogynecologic Society
Description	Percentage of SUI surgeries for which cystoscopy was used during the surgical procedure to reduce complications	Percentage of patients that undergo concurrent cystoscopy at the time of surgery for correction of anterior and/or apical vaginal prolapse to check for lower urinary tract injury.
Type	Process	Process
Data Source	Administrative claims, Paper Medical Records	Administrative claims, Paper Medical Records Practice Patterns Associated with Surgical Care of Pelvic Organ Prolapse: A Targeted Chart Review
Level	Clinician : Individual	Clinician : Group/Practice, Clinician : Individual
Setting	Ambulatory Care : Clinician Office/Clinic	Hospital/Acute Care Facility
Numerator Statement	Female patients who had SUI surgery for which cystoscopy was used during the surgical procedure to reduce complications	Numerator is the number of female patients where a concurrent intraoperative cystoscopy was performed at the time of surgery for correction of anterior and/or apical vaginal prolapse to check for lower urinary tract injury..
Numerator Details	Time Window: The numerator will be calculated using CPT codes.	Time Window: Numerator is measured by all women undergoing any vaginal prolapse repair where a concurrent intraoperative cystoscopy was perform. The cystoscopy will be identified by CPT code(s). Any vaginal prolapse repair will be located int he patient's record using CPT codes for anterior and/or apical vaginal prolapse surgeries.

Denominator Statement	Female patients who had SUI surgeries (without concomitant surgery for prolapse)	Denominator is the number of female patients undergoing any prolapse repair surgery for correction of anterior and/or apical vaginal prolapse.
Denominator Details	Time Window: The denominator will be calculated using CPT codes and patient characteristics, such as gender and age (adult patients). Concomitant prolapse surgery includes repair of cystocele, enterocele, rectocele or vaginal vault prolapse or hysterectomy performed due to uterine prolapse.	Time Window: Denominator is identified as the number of female patients undergoing any prolapse repair surgery for correction of anterior and/or apical vaginal prolapse and these female patients will be identified by using CPT codes for these procedures.
Exclusions	Documentation of medical reason(s) for not using cystoscopy during SUI surgery (patients for whom the use of a cystoscope may not be appropriate, such as the presence of a new cystostomy repair). The panel noted that endoscopy after a new repair should be cautiously used. Concomitant prolapse surgery is an exclusion.	There are no exclusions from the target population.
Exclusion Details	Exclusions will be calculated using CPT codes and patient characteristics, such as gender and age.	There are no exclusions from the target population.
Risk Adjustment	N/A	We are not planning to risk adjust this measure.
Stratification	N/A	We do not plan to stratify the results.
Type Score	N/A	N/A
Algorithm	N/A	N/A

Submission items	**5.1 Identified measures:** 0030 : Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment – A patient reported measure 0098 : Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – an administrative measure 0099 : Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older 0100 : Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older **5a.1 Are specs completely harmonized?** **5a.2 If not completely harmonized, identify difference, rationale, impact:** As a rule, AUA/ACOG seek to harmonize proposed measures with those currently in use for the same topics. For example, the first of the proposed measures "Complete Workup for Assessment of Stress Urinary Incontinence" describes procedures consistent with common standard practices. In developing the proposed set of measures, extant performance measures were considered and kept in mind but were of limited usefulness because they were designed to apply to urinary incontinence in general and to women over 65 years of age. In contrast, we required measures that focused on the surgical intervention for SUI in particular and included women under 65 year of age who constitute the majority of those affected by SUI. **5b.1 If competing, why superior or rationale for additive value:**	**5.1 Identified measures:** **5a.1 Are specs completely harmonized?** **5a.2 If not completely harmonized, identify difference, rationale, impact:** **5b.1 If competing, why superior or rationale for additive value:**