NATIONAL QUALITY FORUM

Measure Submission and Evaluation Worksheet 5.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the submitting standards web page.

NQF #: 0023   **NQF Project:** Population Health: Prevention Project
(for Endorsement Maintenance Review) **Original Endorsement Date:** Aug 10, 2009 **Most Recent Endorsement Date:** Aug 10, 2009 **Last Updated Date:** Apr 25, 2012

BRIEF MEASURE INFORMATION
De.1 Measure Title: Body Mass Index (BMI) in adults > 18 years of age
Co.1.1 Measure Steward: City of New York Department of Health and Mental Hygiene
De.2 Brief Description of Measure: Percentage of adults 18 years old or older with valid BMI documentation in the past 24 month.
2a1.1 Numerator Statement: Adults 18 years old or greater with BMI documented in the past 24 months.
2a1.4 Denominator Statement: Total number of patients 18 years old or greater seen in the measurement period.
2a1.8 Denominator Exclusions: Providers can exclude patients based on medical reason, patient reason, or systemic reason.
1.1 Measure Type: Process **2a1. 25-26 Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record **2a1.33 Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Population : County or City, Population : Regional **1.2-1.4 Is this measure paired with another measure?** No **De.3 If included in a composite, please identify the composite measure** (*title and NQF number if endorsed*)**:**

STAFF NOTES (*issues or questions regarding any criteria*)
Comments on Conditions for Consideration:
Is the measure untested?   Yes☐ No☐   If untested, explain how it meets criteria for consideration for time-limited endorsement:
1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (*check De.5*)**:** **5. Similar/related endorsed or submitted measures** (*check 5.1*)**:** **Other Criteria:**
Staff Reviewer Name(s):

1. IMPACT, OPPORTUNITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT
Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See guidance on evidence. ***Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.*** **(evaluation criteria)**
1a. High Impact: H☐ M☐ L☐ I☐

(*The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.*)

De.4 Subject/Topic Areas *(Check all the areas that apply)***:** Behavioral Health : Screening, Prevention, Prevention : Obesity, Prevention : Screening

De.5 Cross Cutting Areas (*Check all the areas that apply*)**:** Population Health, Prevention, Prevention : Obesity, Prevention : Physical Activity, Prevention : Social Determinants

1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, A leading cause of morbidity/mortality, Patient/societal consequences of poor quality

1a.2 If "Other," please describe:

1a.3 Summary of Evidence of High Impact *(Provide epidemiologic or resource use data)***:**
According to the CDC, nearly 34% of Americans older than 20 are obese. As weight increases, the risks of coronary artery disease, diabetes mellitus, cancers, hypertension, stroke, sleep apnea, and hyperlipidemia also increase. Even modest gains among the prevalence of obesity can translate into a large number of Americans being saved from short and long-term sequela of these diseases. In addition to the morbidity prevented, societal cost savings from healthcare dollars saved can be appreciable as well.

1a.4 Citations for Evidence of High Impact cited in 1a.3: NHLBI/NIDDKD. Clinical Guidelines on the identification, evaluation, and treatment of overweight and obesity in adults. NIH N0. 98-4083, 1998. CDC: (http://www.cdc.gov/obesity/data/index.html)

1b. Opportunity for Improvement: H☐ M☐ L☐ I☐
(*There is a demonstrated performance gap - variability or overall less than optimal performance*)

1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:
Measurement of BMI will lead to 1. identification of the growing problem of obesity among the adult population and 2. encourage programs to halt the increase of the average BMI of the measured population.

1b.2 Summary of Data Demonstrating Performance Gap *(Variation or overall less than optimal performance across providers)***:**
[***For Maintenance** – Descriptive statistics for performance results <u>for this measure</u> - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.*]
In 2007, with approximately 18% of their patients were providers compliant with the BMI measure. The percentages increased steadily to 55% by 2008, 69% by 2009, 76% by 2010, 77% 2011, and 79% 2012. Despite this improvement, nearly 22% of patients do not have a height and weight recorded properly in the EHR in 2012. In addition, we have large variability of measure compliance among the 5 boroughs. There exists nearly a 30% difference in compliance between Queens and Staten Island, for example.

1b.3 Citations for Data on Performance Gap: [*For Maintenance** – Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]
Between 1/11 and 12/11, approximately 613 practices have reported average BMI recording rates. The average times BMI was recorded was 73.0% with a standard deviation of 31.9.

1b.4 Summary of Data on Disparities by Population Group: [*For Maintenance** –Descriptive statistics for performance results <u>for this measure</u> by population group*]
We do not have descriptives of this measure by patient demographics.

1b.5 Citations for Data on Disparities Cited in 1b.4: [*For Maintenance** – Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]
The results were from 613 practices who reported in 2011 representing 4.7 million clinical encounters.

1c. Evidence (*Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.*)
Is the measure focus a health outcome? Yes☐ No☐   If not a health outcome, rate the body of evidence.

Quantity: H☐ M☐ L☐ I☐   Quality: H☐ M☐ L☐ I☐   Consistency: H☐ M☐ L☐ I☐

Quantity	Quality	Consistency	Does the measure pass subcriterion1c?

M-H	M-H	M-H	Yes ☐
L	M-H	M	Yes ☐ IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise **No** ☐
M-H	L	M-H	Yes ☐ IF potential benefits to patients clearly outweigh potential harms: otherwise **No** ☐
L-M-H	L-M-H	L	No ☐

Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service	Does the measure pass subcriterion1c? **Yes** ☐ IF rationale supports relationship

1c.1 Structure-Process-Outcome Relationship *(Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome)***:**
Measuring the body mass index (BMI) is an accepted and common way of screening indivduals for estimated adiposity. By no means perfect, it has been adopted by the government and the industry as a tool for estimating a healthy body weight among sedentary individuals.

1c.2-3 Type of Evidence *(Check all that apply)***:**
Cohort study, Observational study, Evidence-based guideline, Randomized controlled trial, Expert opinion, Systematic synthesis of research, Meta-analysis

1c.4 Directness of Evidence to the Specified Measure *(State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population)***:**
According to the U.S. Preventive Services Task Force, clinicians should screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Since BMI is a more practical tool for routine screening tool than the other methods of measuring body fat, it has been recommended for categorizing patients into weight categories (underweight, overweight, obese, etc.)

1c.5 Quantity of Studies in the Body of Evidence *(Total number of studies, not articles)***:** At least 4 studies have been done that has evaluated BMI as a tool of measuring obesity in adults.

1c.6 Quality of Body of Evidence (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events)***:** Since many other methods of measuring body adiposity is either expensive or impractical, BMI has been found to be a fair to moderate determinant of adult adiposity with some limitations and minimal adverse effects. While not the best measure, it is the one most likely to have a high compliance rate.

1c.7 Consistency of Results across Studies *(Summarize the consistency of the magnitude and direction of the effect):* Many studies have sown BMI to be a reasonable measure of adiposity in adults. Other tests such as mid upper arm circumference measurements or waist to hip ratio are arguably better, these tests are not practical over the course of a routine office visit.

1c.8 Net Benefit *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms)***:**
Most studies have found reasonable sensitivity and specificity of BMI measurements depending on the BMI cutoff level used for men and women. There are few harms from having a measurement of BMI performed except for possible true normal individuals being labelled as overweight and the psychological harm from this misrepresentation.

1c.9 Grading of Strength/Quality of the Body of Evidence. Has the body of evidence been graded? Yes

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: U.S. Preventive Services Task Force (USPSTF)

1c.11 System Used for Grading the Body of Evidence: USPSTF

1c.12 If other, identify and describe the grading scale with definitions:

1c.13 Grade Assigned to the Body of Evidence: Recommended

1c.14 Summary of Controversy/Contradictory Evidence: BMI is not an accurate representation of adiposity in physically active or exceptionally muscular individuals. In addition, BMI percentiles is more useful in children and adolescents than the BMI itself.

1c.15 Citations for Evidence other than Guidelines*(Guidelines addressed below)***:**
McTigue KM, Harris RH, et al. Screening and Interventions for Obesity in Adults. GUide to Clinical Preventive Services, 2001-2004. (http://www.ahrq.gov/clinic/3rduspstf/obesity/obessum.htm)

1c.16 Quote verbatim, the specific guideline recommendation *(Including guideline # and/or page #)***:**
The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
Grade: B Recommendation.

1c.17 Clinical Practice Guideline Citation: Nawaz H, Katz D. American College of Preventive Medicine Medical Practice Policy Statement: Weight Management Counseling for Overweight Adults. Am J Prev Med 2001;21:73-8. Available at www.acpm.org/polstmt_weight.pdf.

1c.18 National Guideline Clearinghouse or other URL: Http://www.ahrq.gov/CLINIC/uspstf/uspsobes.htm

1c.19 Grading of Strength of Guideline Recommendation. Has the recommendation been graded? Yes

1c.20 If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: USPSTF

1c.21 System Used for Grading the Strength of Guideline Recommendation: USPSTF

1c.22 If other, identify and describe the grading scale with definitions:

1c.23 Grade Assigned to the Recommendation: B

1c.24 Rationale for Using this Guideline Over Others: "The USPSTF is an independent panel of non-Federal experts in prevention and evidence-based medicine and is composed of primary care providers (such as internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and health behavior specialists).
    The USPSTF conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems. These recommendations are published in the form of "Recommendation Statements."

Based on the NQF descriptions for rating the evidence, what was the developer's assessment of the quantity, quality, and consistency of the body of evidence?
1c.25 Quantity: Moderate   **1c.26** Quality: Moderate**1c.27** Consistency: Moderate
1c.28 Attach evidence submission form:
1c.29 Attach appendix for supplemental materials:

Was the threshold criterion, *Importance to Measure and Report*, met?
(*1a & 1b must be rated moderate or high and 1c yes*) Yes☐ No☐
Provide rationale based on specific subcriteria:

For a new measure if the Committee votes NO, then STOP.
For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.

2. RELIABILITY & VALIDITY - SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **(evaluation criteria)**

Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See guidance on measure testing.

S.1 Measure Web Page *(In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained)*. Do you have a web page where current detailed specifications for <u>this</u> measure can be obtained? No

S.2 If yes, provide web page URL:

2a. RELIABILITY. Precise Specifications and Reliability Testing: H☐ M☐ L☐ I ☐

2a1. Precise Measure Specifications. (*The measure specifications precise and unambiguous.*)

2a1.1 Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome)***:**
Adults 18 years old or greater with BMI documented in the past 24 months.

2a1.2 Numerator Time Window *(The time period in which the target process, condition, event, or outcome is eligible for inclusion)***:**
past 24 months

2a1.3 Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, codes with descriptors, and/or specific data collection items/responses***:**
Height and weight need to be recorded in as structured format so that a resulting valid BMI can be calculated

2a1.4 Denominator Statement *(Brief, narrative description of the target population being measured)***:**
Total number of patients 18 years old or greater seen in the measurement period.

2a1.5 Target Population Category *(Check all the populations for which the measure is specified and tested if any)***:**

2a1.6 Denominator Time Window *(The time period in which cases are eligible for inclusion)***:**
24 months

2a1.7 Denominator Details (*All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)***:**
Age documented in the patients demographic screen during check-in and a documented valid E&M code for the visit

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)***:**
Providers can exclude patients based on medical reason, patient reason, or systemic reason.

2a1.9 Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)***:**
Provider can supress a patients inclusion in the denominator by a special button next to the measure and by documenting the reason and timeframe for the suppression. The number of these exclusions are captured and are queryable in our quality measure reports.

2a1.10 Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses)***:**
Measures can be stratified by reporting facility

2a1.11 Risk Adjustment Type *(Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13)***:** No risk adjustment or risk stratification   **2a1.12 If "Other," please describe:**

2a1.13 Statistical Risk Model and Variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.)***:**

2a1.14-16 Detailed Risk Model Available at Web page URL (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL**.** Please supply login/password if needed**:**

2a1.17-18. Type of Score: Continuous variable

2a1.19 Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)***:** Better quality = Score within a defined interval

2a1.20 Calculation Algorithm/Measure Logic*(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)***:**
BMI = lb * 703 / in2

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:

2a1.24 Sampling (Survey) Methodology. If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)**:**

2a1.25 Data Source *(Check all the sources for which the measure is specified and tested*). If other, please describe**:**
 Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

2a1.26 Data Source/Data Collection Instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*)**:** eClinicalWorks at http://www.eclinicalworks.com/

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment: URL
http://www.eclinicalworks.com/

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested)***:**   Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Population : County or City, Population : Regional

2a1.34-35 Care Setting *(Check all the settings for which the measure is specified and tested)***:** Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic

2a2. Reliability Testing. (*Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability*.)

2a2.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
By using our electronic health records, we get information from all of our providers and practices transmitted to us monthly. Since every practice transmits information, barring transmission issues or human error, we do not need sampling but instead have all of the data. The data is sen tot us from 613 small and medium sized practices from the 5 boroughs of NYC. The data is sent once a month to us at the NYC DOHMH for analysis. It represents nearly 2 million unique patients in calendar year 2011.

2a2.2 Analytic Method *(Describe method of reliability testing & rationale)***:**
By calculating the measure over the course of time, there has been a consistent and logical progression of the measure. A small chart review has shown that the electronic numbers seem to be valid.

2a2.3 Testing Results *(Reliability statistics, assessment of adequacy in the context of norms for the test conducted)***:**
A chart review of 57 practices have shown a nearly 99% usage of the vitals section where at least one vital sign was stored. However, the percentage of time where both height and weight are stored for a valid BMI to be captured is around 73%.

2b. VALIDITY. Validity, Testing, <u>including all Threats to Validity</u>: H☐ M☐ L☐ I☐

2b1.1 Describe how the measure specifications *(measure focus, target population, and exclusions)* **are consistent with the evidence cited in support of the measure focus (***criterion 1c***) and identify any differences from the evidence:**
The measure specifications are consistent with the measure specifications. It is focusig on all adults 18 and over who are seen during a valid clinical encounter.

2b2. Validity Testing. (*Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.)*

2b2.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
By using our electronic health records, we get information from all of our providers and practices transmitted to us monthly. Since every practice transmits information, barring transmission issues or human error, we do not need sampling but instead have all of the data.

2b2.2 Analytic Method *(Describe method of validity testing and rationale; if face validity, describe systematic assessment)***:**

2b2.3 Testing Results *(Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment)***:**

POTENTIAL THREATS TO VALIDITY. (*<u>All</u> potential threats to validity were appropriately tested with adequate results.*)

2b3. Measure Exclusions. (*Exclusions were supported by the clinical evidence in 1c or appropriately tested with results demonstrating the need to specify them.*)

2b3.1 Data/Sample for analysis of exclusions *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
No specific measure exclusions are used. Only if there is a patient reason to refuse being measured.

2b3.2 Analytic Method (*Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference)***:**

2b3.3 Results *(Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):*

2b4. Risk Adjustment Strategy. (*For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.*)

2b4.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**

No risk adjustment was applied

2b4.2 Analytic Method (*Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables)***:**

2b4.3 Testing Results *(Statistical risk model: Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata)***:**

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment: The measure of BMI is not dependent on age, sex, or other patient characteristic.

2b5. Identification of Meaningful Differences in Performance. (*The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.*)

2b5.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
Data analysis suggests there are large differences in documenting BMI among practices more than 400 practices. Among our providers the highest is 100% and the lowest is 0% with an average of 71.0%.

2b5.2 Analytic Method *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance)***:**
We will analyze all results from the providers and identify practices which are more than one standard deviation lower than the average and target them for intervention.

2b5.3 Results *(Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance):*

2b6. Comparability of Multiple Data Sources/Methods. (*If specified for more than one data source, the various approaches result in comparable scores.*)

2b6.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**

2b6.2 Analytic Method *(Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure)***:**

2b6.3 Testing Results *(Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted)***:**

2c. Disparities in Care: H☐ M☐ L☐ I ☐ NA☐ (*If applicable, the measure specifications allow identification of disparities.*)

2c.1 If measure is stratified for disparities, provide stratified results *(Scores by stratified categories/cohorts)***:**

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:

2.1-2.3 Supplemental Testing Methodology Information:

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met?
(***Reliability and Validity must be rated moderate or high***) Yes☐   No☐
Provide rationale based on specific subcriteria:

If the Committee votes No, STOP

3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. **(evaluation criteria)**

C.1 Intended Actual/Planned Use *(Check all the planned uses for which the measure is intended)***:**   Public Health/Disease Surveillance, Public Reporting, Quality Improvement (Internal to the specific organization)

3.1 Current Use *(Check all that apply; for any that are checked, provide the specific program information in the following questions)*: Public Reporting, Public Health/ Disease Surveillance, Quality Improvement (Internal to the specific organization)

3a. Usefulness for Public Reporting: H☐ M☐ L☐ I ☐
(*The measure is meaningful, understandable and useful for public reporting.*)

3a.1. Use in Public Reporting - disclosure of performance results to the public at large *(If used in a public reporting program, provide name of program(s), locations, Web page URL(s)).* If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: **[For *Maintenance* –** *If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.***]**
EHearts, a pilot incentive program, will reward and recognize electronic health record (EHR)-enabled practices for achieving excellent heart health in patients. eHearts uses EHR-generated clinical quality outcomes as a basis for its pay-for-performance incentive. (please see www.nyc.gov/pcip)

3a.2.Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results**:** Measuring BMI on a patient is the first step for a meaningful discussion between the provider and patient concerning the patient´s health status. If an "overweight" patient is characterized, the odds of a discussion concerning diet, exercise, or cardiovascular risk are much higher. BMI is also an important variable in many prognostic tools.

3.2 Use for other Accountability Functions (payment, certification, accreditation). If used in a public accountability program, provide name of program(s), locations, Web page URL(s)**:**

3b. Usefulness for Quality Improvement: H☐ M☐ L☐ I ☐
(*The measure is meaningful, understandable and useful for quality improvement.*)

3b.1. Use in QI. If used in quality improvement program, provide name of program(s), locations, Web page URL(s):
[For *Maintenance* – *If not used for QI, indicate the reasons and describe progress toward using performance results for improvement***]**.
BMI measure is used by the Clinical Quality Specialist at the Primary Care information Project (PCIP) at the NYC DOHMH in order to have the providers categorize patients as either normal, overweight, or obese. More imformation at
http://www.nyc.gov/html/doh/html/pcip/improve-quality.shtml

3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement. If usefulness was demonstrated *(e.g., QI initiative),* describe the data, method and results:
BMI is not the best way of measring a patient´s body adiposity but it is good and the most convenient and in line with existing practice workflows. Measuring patient´s adiposity is crucial because it is linked to several comorbidities such as hypercholesterolemia, diabetes, and joint problems. These comorbidities have in turn been linked to significant cardiovascular

outcomes.

Overall, to what extent was the criterion, *Usability*, met? H☐ M☐ L☐ I☐
Provide rationale based on specific subcriteria:

4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. **(evaluation criteria)**

4a. Data Generated as a Byproduct of Care Processes: H☐ M☐ L☐ I☐

4a.1-2 How are the data elements needed to compute measure scores generated? *(Check all that apply).*
Data used in the measure are**:**
generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition

4b. Electronic Sources: H☐ M☐ L☐ I☐

4b.1 Are the data elements needed for the measure as specified available electronically *(Elements that are needed to compute measure scores are in defined, computer-readable fields)***:** ALL data elements in electronic health records (EHRs)

4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources:

4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences: H☐ M☐ L☐ I☐

4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:
Height and weight need to be recorded as viable, structured data otherwise BMI can not be calculated.

4d. Data Collection Strategy/Implementation: H☐ M☐ L☐ I☐

A.2 Please check if either of the following apply (*regarding proprietary measures*)**:**
4d.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues *(e.g., fees for use of proprietary measures)***:**
We have learned that there have been some issues in some versions of the EHR where height and weight were not recorded in a structured format but they were remedied by having the EHR accept only valid, structured numbers and no free text.

Overall, to what extent was the criterion, *Feasibility*, met? H☐ M☐ L☐ I☐
Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes☐ No☐
Rationale:

If the Committee votes No, STOP.
If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

5. COMPARISON TO RELATED AND COMPETING MEASURES

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure before a final recommendation is made.

5.1 If there are related measures *(either same measure focus or target population)* **or competing measures** *(both the same measure focus and same target population)***, list the NQF # and title of all related and/or competing measures:**

0024 : Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

5a. Harmonization

5a.1 If this measure has EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized? Yes

5a.2 If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden:

5b. Competing Measure(s)

5b.1 If this measure has both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures *(e.g., a more valid or efficient way to measure quality)***; OR provide a rationale for the additive value of endorsing an additional measure.** *(Provide analyses when possible)***:**

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): City of New York Department of Health and Mental Hygiene, 42-09 28th Street, CN-52, Long Island City, New York, 11101-4132

Co.2 Point of Contact: Sam, Amirfar, MD MS, samirfa1@health.nyc.gov, 347-396-4891-

Co.3 Measure Developer if different from Measure Steward: City of New York Department of Health and Mental Hygiene, 42-09 28th Street, CN-52, Long Island City, New York, 11101-4132

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Co.5 Submitter: Sam, Amirfar, MD MS, samirfa1@health.nyc.gov, 347-396-4891-, City of New York Department of Health and Mental Hygiene

Co.6 Additional organizations that sponsored/participated in measure development:

Co.7 Public Contact: Sam, Amirfar, MD MS, samirfa1@health.nyc.gov, 347-396-4891-, City of New York Department of Health and Mental Hygiene

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development
Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

Ad.2 If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward:

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.3 Year the measure was first released: 2009
Ad.4 Month and Year of most recent revision: 07
Ad.5 What is your frequency for review/update of this measure? annual
Ad.6 When is the next scheduled review/update for this measure? 07, 2012

Ad.7 Copyright statement:

Ad.8 Disclaimers:

Ad.9 Additional Information/Comments:

Date of Submission (*MM/DD/YY*)**:** 07/15/2011