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 #: 1690   **NQF Project:** Population Health: Prevention Project
(for Endorsement Maintenance Review) **Original Endorsement Date: Most Recent Endorsement Date: Last Updated Date:** May 02, 2012
BRIEF MEASURE INFORMATION
De.1 Measure Title: Adult BMI Assessment
Co.1.1 Measure Steward: NCQA
De.2 Brief Description of Measure: The percentage of adults 18–74 years of age who had body mass index (BMI) documented.
2a1.1 Numerator Statement: The percentage of adults 18–74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior the measurement year.
2a1.4 Denominator Statement: Adults 18-74 years of age who had an outpatient visit
2a1.8 Denominator Exclusions: Optional Exclusion: Adults who have a diagnosis of pregnancy during the measurement year or the year prior
1.1 Measure Type: Process **2a1. 25-26 Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records **2a1.33 Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Health Plan, Population : National **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*)**:** N/A

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*)**:**   Prevention, Prevention : Development/Wellness, Prevention : Obesity
De.5 Cross Cutting Areas (*Check all the areas that apply*)**:**   Population Health

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*)**:**
Obesity is the second leading cause of preventable death in the United States. It is a complex multifaceted chronic disease that impacted by environmental, genetic, physiological, metabolic, behavioral and psychological components. Currently, there are approximately 127 million adults in the U.S. who are overweight, 60 million who are obese and 9 million who are severely obese (AOA 2005). Obesity affects individuals from every ethnic group, socioeconomic class and geographic region of the U.S. This disease has been growing by epidemic proportions, with prevalence increasing by approximately 50% per decade. Not only has the prevalence increased, but obesity's impact on individual overall health has drastically increased as well. Obesity increases both morbidity and mortality rates, in addition to increasing the risk for conditions such as diabetes, coronary heart disease and cancer. Obesity has been shown to have a substantial negative effect on longevity, reducing the lifespan of people who are severely obese by an estimated 5–20 years (Olshansky 2005). Excess weight and obesity are contributing causes to more than 50% of all-cause mortality among American adults aged 20–74 years, which results in a significant economic impact—approximately $99.2 billion is spent annually on obesity-related medical care and disability in the U.S (Thomas 2003).

1a.4 Citations for Evidence of High Impact cited in 1a.3: American Obesity Association, AOA Fact Sheets: What is Obesity; Obesity in the U.S.; and Health Effects of
Obesity. http://www.obesity.org/subs/fastfacts/aoafactsheets.shtml. March 2005.
Olshansky, S., D. Passaro, et al. A Potential Decline in Life Expectancy in the United States in the 21st
Century. New England Journal of Medicine. 2005. 352:11: 1138–1145.
Thomas, A., B. Hodges, et al. Obesity in Women: A Guide to Assessment and Management. Brigham and
Women's Hospital, Boston, MA. http://www.brighamandwomens.org/medical/guidelines.asp. 2003

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:
Assessing BMI provides patients with important information about their health and health risks that are modifiable by counseling and behavior changes.

1b.2 Summary of Data Demonstrating Performance Gap (*Variation or overall less than optimal performance across providers*)**:**
[***For Maintenance** – Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.*]
Commercial

Data Element; 2009; 2008;.
N; 170; 158;.
MEAN; 41.3; 33.6; .
STDEV; 23.8; 23.5; .
STDERR; 1.82; 1.87; .
MIN; 0.45; 0.3; .
MAX; 98.5; 97.8; .
P10; 1.23; 0.81; .
P25; 28.3; 18.1; .
P50; 42.4; 30.4; .
P75; 58; 48.2; .

P90; 71.5; 68.9; .

Medicare

Data Element; 2009; 2008;.
N; 290; 179; .
MEAN; 38.8; 32.3; .
STDEV; 24.3; 25.2; .
STDERR; 1.43; 1.88; .
MIN; 0; 0; .
MAX; 99; 97; .
P10; 5.17; 1.25; .
P25; 21.9; 12.7; .
P50; 35.9; 28.5; .
P75; 52.8; 46.3; .
P90; 74.4; 72.7; .

Medicaid

Data Element; 2009; 2008; .
N;94;85; .
MEAN; 34.6; 24; .
STDEV; 21.1; 20.1; .
STDERR; 2.18; 2.18; .
MIN; 0.83; 0.07; .
MAX; 87.5; 91.6; 0
P10; 2.61; 1.12; .
P25; 22.4; 2.57; .
P50; 35.3; 24.1; .
P75; 48.7; 37.2; .
P90; 60.8; 49.3; .

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*]
Section 1b.2 references data from the most recent three years of measurement for HEDIS. Some rates and measures are new; therefore, data might only be available for one or two years. The data in section 1b.2 includes percentiles, mean, min, max, standard deviation and standard error.

1b.4 Summary of Data on Disparities by Population Group: [*For Maintenance* –*Descriptive statistics for performance results for this measure by population group*]
NCQA has participated with IOM and others in attempting to include information on disparities in measure data collection. However, at the present time, this data, at all levels (claims data, paper chart review, and electronic records), is not coded in a standard manner, and is incompletely captured. There are no consistent standards for what entity (physician, group, plan, employer) should capture and report this data. While "requiring" reporting of the data could push the field forward, it has been our position that doing so would create substantial burden with inability to use the data because of its inconsistency. At the present time, we agree with the IOM report that disparities are best considered by the use of zip code analysis which has limited applicability in most reporting situations. At the health plan level, for HEDIS health plan data collection, NCQA does have extensive data related to our use of stratification by insurance status (Medicare, Medicaid and private-commercial) and would strongly recommend this process where the data base supporting the measurement includes this information. However, we believe that the measure specifications should NOT require this since the measure is still useful where the data needed to determine disparities cannot be ascertained from the data available.

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]
N/A

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*):

1c.2-3 Type of Evidence (*Check all that apply*)**:**
Clinical Practice Guideline

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*)**:**
Obesity elevates the risk of diabetes, coronary artery disease, cancer and other conditions. The lifetime risk of diabetes among people born in the U.S. has increased from 30% to 40%, and this increase is directly attributable to the obesity epidemic (Olshansky 2005) The increased risk of diseases such as diabetes and cardiovascular disease directly shortens life expectancy. For instance, having diabetes in adulthood increases the risk of a heart attack as much as having a previous heart attack, and diabetes shortens life expectancy by approximately 13 years (Olshansky 2005).

Facts suggest that the prevalence and severity of obesity and its complications (comorbidities) will worsen and the rates of obesity-induced death will rise: the prevalence of obesity is expected to rise, especially among children; the distribution of the current overweight and obese adult populations are drastically shifting, with more and more adults moving from mild to moderate/severe BMI levels; and obesity is becoming a long-term problem, with children and young adults carrying obesity-related risks for more of their life compared to previous generations (Olshansky 2005).

Despite the significant impact of overweight and obesity on the U.S. population, surveys indicate physicians are not routinely assessing body mass during office visits, nor are they offering advice to obese adults to lose weight. Physicians report that they often fail to counsel patients regarding weight, diet, or exercise and often do not assess body mass during office visits (Jackson 2005).

It is estimated that the aggregate costs of obesity range from 5%–7% of the total annual medical expenditures in the United States ($75 billion per year) (Finkelstein 2003, 2005). The cost of obesity to U.S. business in 1994 was estimated to total $12.7 billion–$10.1 billion due to moderate or severe obesity and $2.6 due to mild obesity. Research has attributed billions in business expenditures to obesity, including paid sick leave and life and health insurance, totaling $2.4 billion, $1.8 billion, and $800 million respectively (Thompson 1998).

Not only is the prevalence of obesity increasing, but the relative per capita spending on obese Americans is also increasing. That increase accounts for 27% of the growth in real per capita spending between 1987 and 2001. The increase spending is due to two

trends: the increase in obesity prevalence and the increase in spending on the obese, relative to those of normal weight (Thorpe 2004). Within that same time frame, the prevalence of obesity increased by 10.3 percentage points to almost 24% of the adult population (Thorpe 2004). This rise in obesity is directly correlated to drastic increases in the incidence of three major conditions: diabetes, hyperlipidemia and heart disease.

1c.5 Quantity of Studies in the Body of Evidence *(Total number of studies, not articles)***:**

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)***:** High. In general the overall quality of evidence for this specific measure would be fair.

1c.7 Consistency of Results across Studies *(Summarize the consistency of the magnitude and direction of the effect):* Consistent

1c.8 Net Benefit *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms)***:** The USPSTF determined there was a positive net benefit

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: 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:

1c.14 Summary of Controversy/Contradictory Evidence: There are a number of clinical guidelines stating that BMI assessment is the first step in treating overweight and obesity, but the impact of this assessment has not been tested to see how it will directly impact the prevalence and severity of the condition.

1c.15 Citations for Evidence other than Guidelines*(Guidelines addressed below)***:**
• Finkelstein EA, Fiebelkorn IC, Wang G. 2003. National medical spending attributable to overweight and obesity: how much, and who's paying? Health Aff Suppl. W3-219-26.
• Finkelstein EA, Ruhm CJ, Kosa KM. 2005. Economic causes and consequences in obesity. Annu Rev Public Health. 26:239-257.
• Thomas A, Hodges, B, et al. 2003. Obesity in Women: A Guide to Assessment and Management. Brigham and Women's Hospital, Boston, MA. Accessed via: http://www.brighamandwomens.org/medical/guidelines.asp.
• Thompson D, Brown JB et al. 1998. Estimated economic costs of obesity to U.S. business. Am J Health Promot. 13(2):120-127.
• Thompson D, Brown JB, et al. 2001. Body mass index and future healthcare costs: a retrospective cohort study. Obes Res. 9(3):210-218.
• Thorpe K, Florence C, Howard D, Joski P, The Impact of Obesity on Rising Medical Spending, Health Affairs Web Exclusive, October 20, 2004.

1c.16 Quote verbatim, <u>the specific guideline recommendation</u> *(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: Screening for Obesity in Adults, Topic Page. December 2003. U.S. Preventive Services Task Force. http://www.uspreventiveservicestaskforce.org/uspstf/uspsobes.htm

1c.18 National Guideline Clearinghouse or other URL: http://www.uspreventiveservicestaskforce.org/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:

1c.24 Rationale for Using this Guideline Over Others: It is NCQA policy to use guidelines which are evidence-based, applicable to physicians and other healthcare providers, and developed by a national specialty organization or government agency.

NCQA convened an expert panel of diverse stakeholders to review the guidelines and evidence for this measure. The panel determined the measure was scientifically sound using the full body of evidence and guidelines for this measure concept.

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: High   **1c.26** Quality: High **1c.27** Consistency: High
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, as specified, 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 this measure can be obtained? Yes

S.2 If yes, provide web page URL: www.ncqa.org/tabid/59/Default.aspx

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)***:**
The percentage of adults 18–74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior the measurement year.

2a1.2 Numerator Time Window *(The time period in which the target process, condition, event, or outcome is eligible for inclusion)*:
The measurement year (12 month calendar year) or the year prior.

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)*:
ADMINISTRATIVE SPECIFICATION:
BMI during the measurement year or the year prior to the measurement year as identified using the following codes:
HCPCS: G8417-G8420; ICD-9-CM Diagnosis:V85.0-V85.5

MEDICAL RECORD SPECIFICATION:
BMI during the measurement year or the year prior to the measurement year. Documentation in the medical record must indicate the date of the BMI and the BMI value.
For patients younger than 19 years on the date of service, documentation of BMI percentile also meets criteria:
• BMI percentile documented as a value (e.g., 85th percentile)
• BMI percentile plotted on an age-growth chart.

2a1.4 Denominator Statement *(Brief, narrative description of the target population being measured)*:
Adults 18-74 years of age who had an outpatient visit

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

2a1.6 Denominator Time Window *(The time period in which cases are eligible for inclusion)*:
The measurement year (12 month calendar year) or the year prior.

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)*:
CPT
99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456

HCPCS
G0344, G0402

ICD-9-CM Diagnosis
V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

UB Revenue
051x, 0520-0523, 0526-0529, 0982, 0983

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)*:
Optional Exclusion: Adults who have a diagnosis of pregnancy during the measurement year or the year prior

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)*:
ICD-9-CM Diagnosis for pregnancy
630-679, V22, V23, V28

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)*:

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: Rate/proportion

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 = Higher score

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.)***:**
Step 1. Determine the eligible population. The eligible population is all members who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement.
Step 2. Search administrative systems and pharmacy data to identify numerator events for all members in the eligible population.
Step 3. If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured. Note: This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.
Step 4. Exclude from the eligible population members from step 3 for whom administrative system data identified an exclusion to the service/procedure being measured.
Step 5. Calculate the rate.

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)**:**
Medical Record Specification
A systematic sample drawn from the eligible population. Use the Medical Record Method or the Hybrid Method to identify the eligible population. Refer to the following sections in the General Guidelines.
• The Medical Record Method
• The Hybrid Method
• Sampling Methods

For this physician-level measure, we anticipate the entire population will be used in the denominator. If a sample is used, a random sample is ideal. NCQA's work has indicated that a sample size of 30-50 patients would be necessary for a typical practice size of 2000 patients.

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

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.*)**:** NCQA collects Healthcare Effectiveness Data and Information Set (HEDIS)

data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal – the Interactive Data Submission System (IDSS)

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

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, Health Plan, Population : National

2a1.34-35 Care Setting (*Check all the settings for which the measure is specified and tested*)**:** 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*)**:**
The data exist in HEDIS Performance Measurement data 2011.

2a2.2 Analytic Method (*Describe method of reliability testing & rationale*)**:**
Reliability was estimated by using the beta-binomial model. Beta-binomial is a better fit when estimating the reliability of simple pass/fail rate measures as is the case with most HEDIS® health plan measures. The beta-binomial model assumes the plan score is a binomial random variable conditional on the plan´s true value that comes from the beta distribution. The beta distribution is usually defined by two parameters, alpha and beta. Alpha and beta can be thought of as intermediate calculations to get to the needed variance estimates. The beta distribution can be symmetric, skewed or even U-shaped.
Reliability used here is the ratio of signal to noise. The signal in this case is the proportion of the variability in measured performance that can be explained by real differences in performance. A reliability of zero implies that all the variability in a measure is attributable to measurement error. A reliability of one implies that all the variability is attributable to real differences in performance. The higher the reliability score, the greater is the confidence with which one can distinguish the performance of one plan from another. A reliability score greater than or equal to 0.7 is considered very good.

2a2.3 Testing Results (*Reliability statistics, assessment of adequacy in the context of norms for the test conducted*)**:**
Reliability was 1.0 for both the commercial and Medicaid product lines.

2b. VALIDITY. Validity, Testing, including all Threats to Validity: 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 is aligned with current guidelines.

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*)**:**
The Adult BMI Assessment measure was tested for face validity with one panel of experts. Measurement Advisory Panels (MAP) and subject matter workgroups provide the clinical and technical knowledge required to develop the measures. The Adult Obesity Measurement Advisory Panel (OMAP) included 14 experts in adult obesity including representation by consumers, health plans, health care providers and policy makers. NCQA's Committee on Performance Measurement (CPM) oversees the evolution of the measurement set and includes representation by purchasers, consumers, health plans, health care providers and policy makers. This panel is made up of 21 members. The CPM is organized and managed by NCQA, and is responsible for advising NCQA staff on the development and maintenance of performance measures. The CPM also meets with the NCQA Board of Directors to

recommend measures for inclusion in HEDIS. CPM members reflect the diversity of constituencies that performance measurement serves; some bring other perspectives and additional expertise in quality management and the science of measurement. Additional HEDIS Expert Panels and the Technical Advisory Group (TAG) provide invaluable assistance by identifying methodological issues and giving feedback on new and existing measures. See Additional Information: Ad.1. Workgroup/Expert Panel Involved in Measure Development for names and affiliation of expert panel.

2b2.2 Analytic Method *(Describe method of validity testing and rationale; if face validity, describe systematic assessment)***:**
*Step 1: Topic selection is the process of identifying measures that meet criteria consistent with the overall model for performance measurement. There is a huge universe of potential performance measures for future versions of HEDIS. The first step is identifying measures that meet formal criteria for further development.

NCQA staff identifies areas of interest or gaps in care. Clinical expert panels (MAPs—whose members are authorities on clinical priorities for measurement) participate in this process. Once topics are identified, a literature review is conducted to find supporting documentation on their importance, scientific soundness and feasibility. This information is gathered into a work-up format. Refer to What Makes a Measure "Desirable"? The work-up is vetted by NCQA's MAPs, the TAG, the HEDIS Policy Panel and various other panels.

*Step 2: Development ensures that measures are fully defined and tested before the organization collects them. MAPs participate in this process by helping identify the best measures for assessing health care performance in clinical areas identified in the topic selection phase.

Development includes the following tasks.
1.Ensure funding throughout measure testing
2.Prepare a detailed conceptual and operational work-up that includes a testing proposal
3.Collaborate with health plans to conduct field-tests that assess the feasibility and validity of potential measures

The CPM uses testing results and proposed final specifications to determine if the measure will move forward to Public Comment.

*Step 3: Public Comment is a 30-day period of review that allows interested parties to offer feedback to the CPM about new measures or about changes to existing measures.
NCQA MAPs and technical panels consider all comments and advise NCQA staff on appropriate recommendations brought to the CPM. The CPM reviews all comments before making a final decision about Public Comment measures. New measures and changes to existing measures approved by the CPM will be included in the next HEDIS year and reported as first-year measures.

*Step 4: First-year data collection requires organizations to collect, be audited on and report these measures, but results are not publicly reported in the first year and are not included in NCQA's Quality Compass? or in accreditation scoring.

The first-year distinction guarantees that a measure can be efficiently collected, reported and audited before it is used for public accountability or accreditation. This is not testing—the measure was already tested as part of its development—rather, it ensures that there are no unforeseen problems when the measure is implemented in the real world. NCQA's experience is that the first year of large-scale data collection often reveals unanticipated issues.

After collection, reporting and auditing on a one-year introductory basis, NCQA conducts a detailed evaluation of first-year data. The CPM uses evaluation results to decide whether the measure should become publicly reportable or whether it needs further modifications.

*Step 5: Public reporting is based on the first-year measure evaluation results. If the measure is approved, it will be reported in Quality Compass and may be used for scoring in accreditation.

Step 6: Evaluation is the ongoing review of a measure's performance and recommendations for its modification or retirement. Every measure is reevaluated at least every three years. NCQA staff continually monitors the performance of publicly reported measures. Statistical analysis, audit result review and user comments contribute to measure evaluation. Information derived from analyzing the performance of existing measures is used to improve development of the next generation of measures.

Each year, a third of the measurement set is researched for changes in clinical guidelines or health care delivery systems, and the results from previous years are analyzed. Measure work-ups are updated with new information gathered from the literature review, and the appropriate MAPs review the work-ups and the previous year's data. If necessary, the measure specification may be updated or the measure may be recommended for retirement. The CPM reviews recommendations from the evaluation process and approves or rejects the recommendation. If approved, the change is included in the next year's HEDIS Volume 2.

What makes a measure "Desirable"?

Whether considering the value of a new measure or the continuing worth of an existing one, we must define what makes a measure useful. HEDIS measures encourage improvement. The defining question for all performance measurement— "Where can measurement make a difference?"—can be answered only after considering many factors. NCQA has established three areas of desirable characteristics for HEDIS measures, discussed below.

1. Relevance: Measures should address features that apply to purchasers or consumers, or which will stimulate internal efforts toward quality improvement. More specifically, relevance includes the following attributes.

Meaningful: What is the significance of the measure to the different groups concerned with health care? Is the measure easily interpreted? Are the results meaningful to target audiences?
Measures should be meaningful to at least one HEDIS audience (e.g., individual consumers, purchasers or health care systems). Decision makers should be able to understand a measure's clinical and economic significance.

Important to health: What is the prevalence and overall impact of the condition in the U.S. population? What significant health care aspects will the measure address?
We should consider the type of measure (e.g., outcome or process), the prevalence of medical condition addressed by the measure and the seriousness of affected health outcomes.

Financially important: What financial implications result from actions evaluated by the measure? Does the measure relate to activities with high financial impact?
Measures should relate to activities that have high financial impact.

Cost effective: What is the cost benefit of implementing the change in the health care system? Does the measure encourage the use of cost-effective activities or discourage the use of activities that have low cost-effectiveness? Measures should encourage the use of cost-effective activities or discourage the use of activities that have low cost-effectiveness.

Strategically important: What are the policy implications? Does the measure encourage activities that use resources efficiently? Measures should encourage activities that use resources most efficiently to maximize member health.

Controllable: What impact can the organization have on the condition or disease? What impact can the organization have on the measure? Health care systems should be able to improve their performance. For outcome measures, at least one process should be controlled and have an important effect on outcome. For process measures, there should be a strong link between the process and desired outcome.

Variation across systems: Will there be variation across systems? There should be the potential for wide variation across systems.

Potential for improvement: Will organizations be able to improve performance? There should be substantial room for performance improvement.

2. Scientific soundness: Perhaps in no other industry is scientific soundness as important as in health care. Scientific soundness must be a core value of our health care system—a system that has extended and improved the lives of countless individuals.

Clinical evidence: Is there strong evidence to support the measure? Are there published guidelines for the condition? Do the guidelines discuss aspects of the measure? Does evidence document a link between clinical processes and outcomes addressed by the measure? There should be evidence documenting a link between clinical processes and outcomes.

Reproducible: Are results consistent? Measures should produce the same results when repeated in the same population and setting.

Valid: Does the measure make sense? Measures should make sense logically and clinically, and should correlate well with other measures of the same aspects of care.

Accurate: How well does the measure evaluate what is happening? Measures should precisely evaluate what is actually happening.

Risk adjustment: Is it appropriate to stratify the measure by age or another variable? Measure variables should not differ appreciably beyond the health care system's control, or variables should be known and measurable. Risk stratification or a validated model for calculating an adjusted result can be used for measures with confounding variables.

Comparability of data sources: How do different systems affect accuracy, reproducibility and validity? Accuracy, reproducibility and validity should not be affected if different systems use different data sources for a measure.

3. Feasibility:
The goal is not only to include feasible measures, but also to catalyze a process whereby relevant measures can be made feasible.

Precise specifications: Are there clear specifications for data sources and methods for data collection and reporting? Measures should have clear specifications for data sources and methods for data collection and reporting.

Reasonable cost: Does the measure impose a burden on health care systems? Measures should not impose an inappropriate burden on health care systems.

Confidentiality: Does data collection meet accepted standards of member confidentiality?
Data collection should not violate accepted standards of member confidentiality. Logistical feasibility
Are the required data available?

Auditability: Is the measure susceptible to exploitation or "gaming" that would be undetectable in an audit? Measures should not be susceptible to manipulation that would be undetectable in an audit.

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)*:
Step 1: The Adult BMI Assessment measure was developed to address a gap in care concerning the assessment of adults who are overweight or obese. NCQA's Performance Measurement Department and the Adult Obesity MAP worked together to develop a measure that would be most appropriate for the assessment of obesity.

Step 2: The measure was written, field-tested, and presented to the CPM in 2008. The CPM recommended to send the measure to public comment.

Step 3: The measure was released for Public Comment in spring 2008. We received and responded to comments on this measure. The CPM recommended moving this measure to first year data collection with a vote of 1 in favor and none opposed.

Step 4: The Adult BMI Assessment measure was introduced in HEDIS 2009. Organizations reported the measures in the first year and the results were analyzed for public reporting in the following year. The CPM recommended moving this measure public reporting with a vote of 11 in favor and none opposed.

Step 5: The Adult BMI Assessment measure will be reevaluated in 2012.

POTENTIAL THREATS TO VALIDITY. (*All 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 analysis, as exclusion is optional and for pregnancy.

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

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

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 necessary.

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

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)***:**
N/A

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment: N/A

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 demonstrates that methods for scoring and analysis of the specified measure allow for identification of statistically significant and practically/clinically meaningful differences in performance.

2b5.2 Analytic Method (*Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance)***:**
Comparison of means and percentiles; analysis of variance against established benchmarks; if sample size is >400, we would use an analysis of variance.

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):*
 Commercial

Data Element; 2009; 2008;.
N; 170; 158;.
MEAN; 41.3; 33.6; .
STDEV; 23.8; 23.5; .
STDERR; 1.82; 1.87; .
MIN; 0.45; 0.3; .
MAX; 98.5; 97.8; .
P10; 1.23; 0.81; .
P25; 28.3; 18.1; .

P50; 42.4; 30.4; .
P75; 58; 48.2; .
P90; 71.5; 68.9; .

Medicare

Data Element; 2009; 2008;.
N; 290; 179; .
MEAN; 38.8; 32.3; .
STDEV; 24.3; 25.2; .
STDERR; 1.43; 1.88; .
MIN; 0; 0; .
MAX; 99; 97; .
P10; 5.17; 1.25; .
P25; 21.9; 12.7; .
P50; 35.9; 28.5; .
P75; 52.8; 46.3; .
P90; 74.4; 72.7; .

Medicaid

Data Element; 2009; 2008; .
N;94;85; .
MEAN; 34.6; 24; .
STDEV; 21.1; 20.1; .
STDERR; 2.18; 2.18; .
MIN; 0.83; 0.07; .
MAX; 87.5; 91.6; 0
P10; 2.61; 1.12; .
P25; 22.4; 2.57; .
P50; 35.3; 24.1; .
P75; 48.7; 37.2; .
P90; 60.8; 49.3; .

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)*:
In the summer of 2007, NCQA conducted a field test, to assess the feasibility of a BMI assessment measure for adults. Three health plans participated in the field test and provided de-identified patient-level data and medical record abstracts to NCQA under the terms of a formal agreement. The enrollments of these three health plans ranged from 8,700 to 392,000 members. Participating plans were located in several geographic regions of the country
Administrative Data Collection
1.	For the data compiled for this project, information was abstracted based on patient records from calendar years 2005 and 2006 only.
2.	Demographic Enrollment Data: was used to verify member eligibility based on age as of 12/31/2006.
3.	Claims/Encounter Data: was used to determine number of member visits, existing diagnoses, types of visits, and claims for BMI assessment.
4.	The full eligible population, as identified via administrative data, was used to determine the sample for medical record review.

Medical Record Data Collection
Manual chart review was required to obtain the appropriate data elements for this study from a sample of the eligible population; plans were required to pull and report on 150 charts. Over-sampling to ensure a total of 150 charts reviewed may have been

necessary. Plans pulled medical records selected from the commercial, Medicare and Medicaid populations used for the administrative portion of the field test. The samples were selected either randomly or by using the HEDIS systematic sampling methodology. Once the sample was identified, the following logic was used to select the medical record for review for each member:

1. Plans reviewed the medical record located at the physician office where the member was most frequently seen during 2005 and 2006.

2. If there was a tie with two or more physicians with the same number of visits, the record at the physician office for the most recent visit was used.

3. If there was no documentation of BMI in the medical record pulled, plans may have used another medical record for that member.

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

The purpose of field testing is to determine:

- The validity of the administrative algorithm to identify the target population (denominator) based upon the measurement period, continuous enrollment /exclusionary criteria

- The validity of administrative data to accurately capture medical processes delivered (i.e. tests) or diagnoses by comparing administrative results with data from a sample of medical records

- The feasibility of the measure specifications to identify the quality problem and to discriminate performance between health plans for the purposes of HEDIS public reporting.

- The reliability and feasibility of the measure specifications so that all health plans can capture the required data elements and can conduct programming

Based upon the field test results, NCQA made necessary revisions to the measure specifications so that it meets the Desirable Attributes of a HEDIS 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)***:**

When requiring an office visit in the measurement year, or year prior, the field test indicates that 86% of the plan's adult population will meet the visit criteria and thus be included in the eligible population.

Of the 156 members with an office visit in 2005 or 2006, only 26% had documentation of BMI. This number varies between plans, from a low of 10% of members to a high of 75% of members. The plan that indicated 67% of members had BMI documented in 2005 or 2006 is the plan that utilized 100% EMR for reporting of results.

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)***:** Measure is not stratified for disparities

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:
NCQA has participated with IOM and others in attempting to include information on disparities in measure data collection. However, at the present time, this data, at all levels (claims data, paper chart review, and electronic records), is not coded in a standard manner, and is incompletely captured. There are no consistent standards for what entity (physician, group, plan, employer) should capture and report this data. While "requiring" reporting of the data could push the field forward, it has been our position that doing so would create substantial burden with inability to use the data because of its inconsistency. At the present time, we agree with the IOM report that disparities are best considered by the use of zip code analysis which has limited applicability in most reporting situations. At the health plan level, for HEDIS health plan data collection, NCQA does have extensive data related to our use of stratification by insurance status (Medicare, Medicaid and private-commercial) and would strongly recommend this process where the data base supporting the measurement includes this information. However, we believe that the measure specifications should NOT require this since the measure is still useful where the data needed to determine disparities cannot be ascertained from the data available.

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

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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)***:** Professional Certification or Recognition Program, Public Health/Disease Surveillance, Public Reporting, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations), Regulatory and Accreditation Programs

3.1 Current Use *(Check all that apply; for any that are checked, provide the specific program information in the following questions)*: Public Reporting, Payment Program, Quality Improvement with Benchmarking (external benchmarking to multiple organizations), 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.*]
This measure is used in public reporting for plans only through Healthcare Effectiveness Data and Information Set (HEDIS) and is reported through venues such as the annual State of Healthcare Quality report, Quality Compass, America's Best Health Plans.

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**:** HEDIS measures adhere to the desirable attributes of scientific acceptability, feasibility and usability. The measures provide performance rates that are audited for consistency and accuracy.

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)**:** Accreditation

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*]**.**
This measure is in the Healthcare Effectiveness Data and Information Set (HEDIS) and is used in NCQA's Health Plan Accreditation program.

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:
Upon review of public comment results, the Committee on Performance Measurement approved the NCQA staff recommendation to add the measure to HEDIS. After reviewing first-year analysis results, the CPM approved the staff recommendation to publicly

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report the measure. The measure was deemed usable and feasible.

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**:**
Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

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)***:** Some data elements are in electronic sources

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: This is a hybrid measure: administrative claims and medical records.

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:
NCQA recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may vary, and other errors may taint the results, diminishing the usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO´s ability to comply with HEDIS specifications (. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.
The HEDIS Compliance Audit addresses the following functions:
1) information practices and control procedures
2) sampling methods and procedures
3) data integrity
4) compliance with HEDIS specifications
5) analytic file production
6) reporting and documentation

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

A.2 Please check if either of the following apply (*regarding proprietary measures*)**:** Proprietary measure
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)***:**
NCQA´s multi-stakeholder advisory panels examined an analysis of the measure after its first year of reporting. The measure was deemed appropriate for public reporting. NCQA has processes to ensure coding and specifications are clear and updated when needed.

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:**
0023 : Body Mass Index (BMI) in adults > 18 years of age

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? No

5a.2 If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden:
The #0023 measure is specified only for clinics utilizing NYCDOHMH electronic health record while our measures is mainly used for health plan level reporting and is not suitable for harmonization. Our measure has an age range of 18-74 years while #0023 measure has an age of 18+ years.

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)***:**
Measure 1690 allows the evaluation of quality for health plans and has been used in HEDIS.

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): NCQA, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia, 20005

Co.2 Point of Contact: Bob, Rehm, MBA, rehm@ncqa.org, 202-955-1728-

Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance, 1100 13th Street NW, Washington, District Of Columbia, 20005

Co.4 Point of Contact: Dawn, Alayon, MPH, CPH, alayon@ncqa.org, 202-955-3533-

Co.5 Submitter: Bob, Rehm, MBA, rehm@ncqa.org, 202-955-1728-, NCQA

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

Co.7 Public Contact: Bob, Rehm, MBA, rehm@ncqa.org, 202-955-1728-, NCQA

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.

The NCQA Adult Obesity Measurement Advisory Panel (MAP) advised NCQA during measure development. They evaluated the way staff specified measures, assessed the content validity of measures, and reviewed field test results. As you can see from the list, the MAP consisted of a balanced group of experts, including representatives from health plans, specialty societies, research institutions, etc. Note that, in addition to the MAP, we also vetted these measures with a host of other stakeholders, as is our process. Thus, our measures are the result of consensus from a broad and diverse group of stakeholders, in addition to the MAP.

David Arterburn, MD, MPH (Co-Chair)
Lawrence Blonde, MD, FACP, FACE
David Brumley, MD
Marc Cornier, MD
Morgan Downey, JD
Leonard (Len) Fromer, MD, FAAFP
LuAnn Heinen, MPP
Trina Histon, PhD
Michael Jensen, MD
Richard A. Kahn, PhD
Samuel Klein, MD
Jaan Sidorov, MD, MHSA
Thomas Stellato, MD
Thomas Wadden, PhD
Peter Wald, MD, MPH

Committee on Performance Measurement (CPM)
Peter Bach, MD, Memorial Sloan Kettering Cancer Center
Bruce Bagley, MD, American Academy of Family Physicians
Andrew Baskin, MD, Aetna
A. John Blair lll, MD, Taconic IPA, Inc
Patrick Conway, MD, MSC, Center for Medicare & Medicaid Services

Jonathan D. Darer, MD, Geisinger Health System
Helen Darling, National Business Group on Health
Foster Gesten, MD, NYSDOH Office of Managed Care
Marge Ginsburg, Center for Healthcare Decisions
Christine S. Hunter, MD, US Office of Personnel Management
George J. Isham, MD, MS, HealthPartners
Jeffrey Kelman, MMSc, MD, Centers for Medicare & Medicaid Services
Lisa Latts, MD, MSPH, MBA, Well Point, Inc.
Arthur Levin, MPH (Co-Chair), Center for Medical Consumers
Philip Madvig, MD, The Permanente Medical Group
Susan Reinhard, RN, PhD, AARP

Bernard M. Rosof, MD, MACP, Huntington Hospital
Eric C. Schneider, MD, MSc (Co-Chair), RAND Corporation
Kevin Weiss, MD, FACP, American Board of Medical Specialties

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: 2010
Ad.5 What is your frequency for review/update of this measure? About every 3 years; sooner if clinical guidelines change significantly

Ad.6 When is the next scheduled review/update for this measure?	
Ad.7 Copyright statement: © 2012 by the National Committee for Quality Assurance 1100 13th Street, NW, Suite 1000 Washington, DC 20005	
Ad.8 Disclaimers:	
Ad.9 Additional Information/Comments:	
Date of Submission (*MM/DD/YY*)**:** 07/12/2011	