TO: Consensus Standards Approval Committee (CSAC)

FR: Elisa Munthali, Senior Project Manager

RE: Population Health Endorsement Maintenance Project: Phase II Member Voting Results*

DA: September 14, 2012

The CSAC reviewed recommendations from the *Population Health Endorsement Maintenance: Phase II* project during its September 10 conference call.

*As announced during the call, the Member vote period for this report concluded on September 13, 2012. Voting results are now available and have been added to this revised memo. The results were also posted to the NQF website. Please refer to the memo dated September 5, 2012 for a summary of the project, recommended measures, themes identified from and responses to the public and member comments.

NQF MEMBER VOTING RESULTS

All of the recommended measures were approved with 86% approval or higher. Representatives of seven member organizations voted; no votes were received from the Consumer, Provider, Public/Community Health Agency, Purchaser or Supplier/Industry Councils. Results for each measure are provided below. (Links are provided to the full measure summary evaluation tables.)

1999: Late HIV Diagnosis

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	4	0	0	4	100%
Health Professional	2	0	0	2	100%
Provider Organizations	0	0	0	0	
Public/Community Health Agency	0	0	0	0	
Purchaser	0	0	0	0	
QMRI	0	0	1	1	
Supplier/Industry	0	0	0	0	
All Councils	**6**	**0**	**1**	**7**	**100%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					100%

*equation: Yes/ (Total - Abstain)

2020: Adult current smoking prevalence

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	4	0	0	4	100%
Health Professional	2	0	0	2	100%
Provider Organizations	0	0	0	0	
Public/Community Health Agency	0	0	0	0	
Purchaser	0	0	0	0	
QMRI	0	0	1	1	
Supplier/Industry	0	0	0	0	
All Councils	**6**	**0**	**1**	**7**	**100%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					100%

*equation: Yes/ (Total - Abstain)

0421: Preventive care and screening: BMI screening and follow-up

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	4	0	0	4	100%
Health Professional	2	0	0	2	100%
Provider Organizations	0	0	0	0	
Public/Community Health Agency	0	0	0	0	
Purchaser	0	0	0	0	
QMRI	0	0	1	1	
Supplier/Industry	0	0	0	0	
All Councils	**6**	**0**	**1**	**7**	**100%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					100%

*equation: Yes/ (Total - Abstain)

0024: Weight assessment and counseling for nutrition and physical activity for children/adolescents

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	3	1	0	4	75%
Health Professional	2	0	0	2	100%

Provider Organizations	0	0	0	0	
Public/Community Health Agency	0	0	0	0	
Purchaser	0	0	0	0	
QMRI	1	0	0	1	100%
Supplier/Industry	0	0	0	0	
All Councils	**6**	**1**	**0**	**7**	**86%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					92%

*equation: Yes/ (Total - Abstain)

0029: Counseling on physical activity in adults – a. Discussing physical activity, b. Advising physical activity

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	3	1	0	4	75%
Health Professional	2	0	0	2	100%
Provider Organizations	0	0	0	0	
Public/Community Health Agency	0	0	0	0	
Purchaser	0	0	0	0	
QMRI	1	0	0	1	100%
Supplier/Industry	0	0	0	0	
All Councils	**6**	**1**	**0**	**7**	**86%**
Percentage of councils approving (>50%)					100%
Average council percentage approval					92%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- America's Health Insurance Plans: This measure can be affected by the time elapsed between when the counseling occurred and when the survey was administered. Ongoing research by David Nutall from the UK has shown rapid decline in memories of physician counseling after 3-6 months.
- Humana, Inc.: This is a self-reported process measure. David Nutall from the British Health Department showed that there is a rapid extinction for memories of physician counseling after 3-6 months.
    - Developer Response: We appreciate the comments from Humana and AHIP which raise a similar issue regarding the recall period of measure #0029 "Counseling on physical activity in older adults." The measure is administered annually to patients through the health outcomes survey. The intent of this measure is to apply as broadly as possible to

all patients who visited a provider in the past year. It encompasses activities which may have occurred recently but also encompasses counseling during a visit which may have not occurred recently (say a visit 9 months ago). We recognize that recall for physician counseling is reduced over time. A shorter recall period of say three months would exclude any individual who did not visit their provider in the past three months and therefore be very limited in sample, likely too small to allow for meaningful comparisons. As with all patient reported measures there is a potential for recall bias. Therefore, NCQA recommends measures which use patient report of processes of care be combined with clinical measures of processes of care to present a complete picture of the quality of care being provided.

Measure Evaluation Summary Tables

LEGEND: Y = Yes; N = No; H = High; M = Moderate; L = Low; I = Insufficient

1999: Late HIV diagnosis

Submission I Specifications

Status: New Submission

Description: Percentage of persons 13 years and older diagnosed with Stage 3 HIV infection (AIDS) within 3 months of a diagnosis of HIV infection.

Numerator Statement: Persons in denominator statement with a diagnosis of Stage 3 HIV infection (AIDS) within 3 months of diagnosis of HIV infection

Denominator Statement: Persons age 13 years and older diagnosed with HIV during specified calendar year.

Risk Adjustment/Stratification: Stratification by risk category/subgroup. Results are routinely stratified by age group (13-19, 20-29, 30-39, 40-49, 50-59, >59), by race/ethnicity (white, Hispanic, Black, Asian, Native Hawaiian/other Pacific Islander, AI/AN) and by transmission category (MSM, MSM/IDU, IDU male, IDU female, heterosexual male, heterosexual female, other).

Exclusions: Persons with month of diagnosis missing are excluded (<0.05%)

Measure Type: Outcome

Data Source: Other

Level of Analysis: Population: State

Measure Steward: Centers for Disease Control and Prevention

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: **The measure meets the Importance criteria.**

(1a. Impact, 1b. Performance gap, 1c. Evidence)

1a. Impact: **H-8; M-3; L-0; I-0;** 1b. Performance gap: **H-7; M-4; L-0; I-0;** 1c. Evidence: **Y-10; N-1**

Rationale:

- Good population-level measure that allows communities to approach testing in varied ways, population-specific. Uses population health data set.
- Assesses the utilization of early screening/testing for HIV in relation to stage of HIV infection. Effectiveness of testing activities in a given state or community.
- Strong evidence that demonstrates the importance of HIV testing to individuals and communities.
- Links health improvement activity (testing) to population health outcome (diagnosis).
- Demonstrates synergy between the clinical care and public health system.
- Data on disparities are well documented.
- The Steering Committee was concerned that the evidence cited for performance gap supported diagnosis of Stage 3 HIV (AIDS) within 12 months (previous iteration of the measure) and not diagnosis within 3 months.

The developer stated that the variability between the number of people diagnosed at 3 and 12 months is low; additionally, the measure is intended to be an assessment of concomitant of being Stage 3 at diagnosis. The timeframes account for the time for seeking care and availability of the first CD4 results that confirm diagnosis. The Steering Committee accepted the developer's response.

1999: Late HIV diagnosis

Scientific Acceptability of Measure Properties: <u>The measure meets the criteria for Scientific Acceptability.</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-4; M-6; L-1; I-0;** 2b. Validity: **H-3; M-7; L-1; I-0**

<u>Rationale:</u>

- The Steering Committee was concerned about cross jurisdictional testing and diagnosis and how these data are captured in the surveillance system.
    - The developer explained that an audit check is conducted with state partners semi-annually to reconcile duplicates in the national database.
- Difficult to conduct retrospective review of referral or follow-up from point of testing without utilizing different data sources.
- Mixed reaction about the effect of HIV home testing on validity:
    - Some Committee members believed it may be an inherent threat to validity and others believed it could strengthen validity because those that test positive will present for care earlier.

  The developer will research if data exist that demonstrate that home testing leads to seeking care earlier.
- Some questions about completeness of HIV and AIDS case reporting, estimated at more than 80%.
    - The developer stated that the surveillance system is evaluated once annually. Various methods of testing include capture-recapture and calculation of the expected numbers based on regression analyses. Furthermore, HIV/AIDs reporting is mandated virtually everywhere. Completeness is extremely high where there's 100% mandated laboratory reporting, HIV diagnostic reports come in, and where all CD4s are reported. The developer acknowledges lags due to turnover and other issues.

Usability: <u>H-6; M-4; L-1; I-0</u>

(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures)

<u>Rationale:</u>

- The Committee believes that the state is the appropriate level of analysis.
- One Committee member asked about the feasibility of drilling down beyond the state level.

  According to the developer, the data could be looked at by state, city, county, census tract and diagnostic facility.

Feasibility: <u>H-5; M-5; L-1; I-0</u>

(*4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions-no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)*

<u>Rationale:</u>

- To adequately ensure the health of populations, we need a screening system that leads to care.

5. Related and Competing Measures
    - No related or competing measures noted.

Steering Committee Recommendation for Endorsement: Y-10; N-1

1999: Late HIV diagnosis

Public & Member Comment

Comment:

- Measure should be used at facility-level in addition to population-level.

  Developer Response: This measure can be used at the facility-level in closed systems, like the VA, that provide the full range of healthcare services. However, we do not believe that it would be useful for a facility where people who may not have been in regular care, seek care when they become symptomatic. As integration of care improves under healthcare reform, the measure will become increasingly useful at the healthcare system level.

Steering Committee response: The Committee accepted the developer's response and did not change their endorsement consideration.

2020: Adult Current Smoking Prevalence

Submission I **Specifications**

Status: New Submission

Description: Percentage of adult (age 18 and older) U.S. population that currently smokes.

Numerator Statement: The numerator is the current adult smokers (age 18 and older) in the U.S.

Denominator: The adult (age 18 and older) population of the U.S.

Risk Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: Persons serving in the military. Persons who are institutionalized.

Measure Type: Structure

Data Source: Other

Level of Analysis: Population: National

Measure Steward: Centers for Disease Control and Prevention

STEERING COMMITTEE EVALUATION:

Importance to Measure and Report: The measure meets the Importance criteria.
(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-9; M-2; L-0; I-0**; **1b.** Performance Gap: **H-5; M-6; L-0; I-0 1c.** Evidence: **Y-10; N-0; I-1**

Rationale:

- Sufficient evidence about the burden of smoking at state and national levels, and evidence-based interventions to reduce the burden.
- Useful community assessment to help determine resource allocation and strategic plans for combatting smoking.

2020: Adult Current Smoking Prevalence

Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: **H-8; M-3; L-0; I-0** **2b.** Validity: **H-7; M-4; L-0; I-0**

Rationale:

- Concern about validity because of the exclusion of people serving in the military and those that are institutionalized. Although these are relatively small populations, smoking prevalence is high among these groups.
- Some Committee members stated an additional limitation of using NHIS as a data source:
    - Lower age limit – perhaps consider those younger than 18 years, which data show high prevalence
- Several concerns about the survey questions and apparent and/or potential lack of harmonization with similar smoking survey measures, including BRFSS etc.
    - "Have you smoked at least 100 cigarettes in your entire life? (Yes, No, Refused, Don't Know)" does not appear to be aligned with other survey questions, which ask "do you smoke every day, some days, or at all…" This former is listed twice in the measure submission form.
- Why are non-combustibles and other tobacco products omitted from the measure?

Following the in-person meeting, the steward and developer provided the following responses:

- The measure, as currently specified, is based on the National Health Interview Survey (NHIS) measure of current smoking, which tracks the Healthy People 2020 measure for smoking prevalence among adults.
- The measure uses the following questions, which are harmonized with BRFSS:
    - Have you smoked at least 100 cigarettes in your entire life? (Yes, No, Refused, Don't Know) and,
    - Do you now smoke every day, some days, or not at all (asked of those who smoked 100 cigarettes in the above question)? (Every day, Some days, Not at all, Refused, Don't know)

The developer has since agreed to utilize the BRFSS question for smoking prevalence, which can be assessed at the state level. The developer will update the measure submission form accordingly. In response to the Committee's concern about non-combustible tobacco products, the CDC recognizes the importance of this assessment and adds that some of their surveys "…are moving towards a question like: *In the past 30 days have you smoked a cigarette, cigar or pipe* (FDA/NIDA proposed question in PATH study) and a separate question on non-combustibles like, *In the past 30 days have you used smokeless tobacco such as chewing tobacco, snuff, snus, or dip* (FDA/NIDA proposed question in PATH study)." The CDC and the developer are considering the addition of a question on non-combustibles in a future iteration of the measure.

2020: Adult Current Smoking Prevalence
Usability: H-9; M-2; L-0; I-0 *(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures)* Rationale: • Concern about the incentive to drive quality improvement at the national level only, if the measure cannot be drilled down to lower levels of aggregation. • Consider harmonization with other measures. For example, smoking-related measure from NCQA in ongoing Behavioral Health project. Need more to review measure specifications – what questions are used in NCQA's CAHPS survey measure? Are these aligned with other national surveys?
Following the meeting, the developer agreed to use BRFSS' state-level smoking prevalence measure. The developer will revise the measure submission accordingly. In addition, NQF staff reviewed NCQA's 0027: Medical assistance with smoking and tobacco use cessation. The survey questions used to assess smoking prevalence are generally standardized, except NCQA also assess tobacco use. The survey reads, "Do you now smoke cigarettes or use tobacco every day, some days, or not at all." CDC asks, "Do you know smoke cigarettes every day, some days, or not at all".
Feasibility: H-8; M-3; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions-no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)* Rationale: • Data are accessible from existing survey.
5. Related and Competing Measures This measure is related to measure #0027: Medical assistance with smoking and tobacco use cessation, which is currently under endorsement consideration in an on-going behavioral health project. The Committee largely supported the endorsement of this measure per the suggested revision, but also encourages harmonization with measure #0027 if possible.
Steering Committee Recommendation for Endorsement: Y-10; N-0 Rationale: The Committee is in favor of developer's proposed revision to use the BRFSS survey questions. <u>Recommendation:</u> • The Steering Committee encourages harmonization with NCQA's measure #0027 Medical assistance with smoking and tobacco use cessation if possible.

2020: Adult Current Smoking Prevalence

Public & Member Comment

Comments include:

- Concerns about the systematic biases related to validity and accuracy of responses across different populations for patient-reported data.

  Developer response: This measure assesses members of the population, not patients. Generally, self-reported smoking status is a valid indicator of population-level smoking prevalence, and most national surveys in the United States that assess health behavior rely on self-reported data, such as NHIS and NSDUH. A study by Assaf et al., which examined potential gender differences in self-reported smoking data, compared self-reported smoking behavior to serum thiocyanate and serum cotinine levels. The authors concluded that although there were some differences in self-reporting of smoking status by gender, the results were similar between self-reports and biochemical tests. The authors asserted that the results lent "credibility to the use of self-reports as low-cost accurate approach to obtaining information on smoking behaviors among both men and women in large population-based surveys" (Assaf 2002).

- Harmonize measure 2020 with measure 0027 Medical assistance with smoking tobacco use cessation (under consideration in the ongoing Behavioral Health project).

  Developer response: The two metrics assess different aspects of smoking and/or tobacco use. The denominator population for measure 0027 includes health plan members that currently smoke and use tobacco and those that have received tobacco use and smoking cessation advice during a specific time period. Measure 2020 assesses current smoking prevalence (only) among the adult population in the United States. Therefore, harmonization would not be practical or necessary.

- Include military personnel in the measure's denominator.

  Developer response: This would be ideal. While the BRFSS does not include this population in their sample, there is no reason why future iterations of this measure could not accurately assess smoking status in the military as compared to the general population. Many studies examining smoking status in a military population have relied on self-reported data and have used measures similar to the measure used in the BRFSS.

- Include an assessment of smokeless tobacco.

  Developer response: This would require a separate measure, with specific validity and reliability testing data. This current smoking prevalence measure is thoroughly tested and has been in use for several years.

Steering Committee response: The Committee accepted the developer's responses and did not change their endorsement consideration. The Committee agreed that military personnel and smokeless tobacco are important assessments to add to the measure in the future.

0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

Submission I Specifications

Status: Maintenance, Original Endorsement: July 31, 2008

Description: Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented

Normal Parameters: Age 65 years and older BMI > = to 23 and <30, Age 18 – 64 years BMI > = to 18.5 and <25

Numerator Statement: ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION. Patients with BMI calculated within the past six months or during the current visit and a follow-up plan documented if the BMI is outside of parameters

Denominator Statement: ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION. All patients aged 18 years and older on date of encounter seen during the 12 month reporting period with one or more denominator CPT or HCPCS encounter codes reported on the Medicare Part B Claims submission for the encounter along with one of the 6 numerator HCPCS clinical quality codes. All discussed coding is listed in "2a1.7 Denominator Details" section below.

Exclusions: ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION. A patient is identified as a Denominator Exclusions (B) and excluded from the Total Denominator Population (TDP) in the Performance Denominator (PD) calculation if one or more of the following reason (s) exist:

- There is documentation in the medical record that the patient is over or under weight and is being managed by another provider
- If the patient has a terminal illness-life expectancy is 6 months or less
- If the patient is pregnant
- If the patient refuses BMI measurement
- If there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate
- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

Adjustment/Stratification: N/A

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Population : County or City, Population : National, Population : Regional, Population : State

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Medical Records

Measure Steward: Centers for Medicare and Medicaid Services

0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

STEERING COMMITTEE MEETING [05/30/2012]

Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-6; M-4; L-0; I-0; 1b.** Performance Gap: **H-8; M-0; L-2; I-0** 1c. Evidence: **Y-8; N-1**

<u>Rationale:</u>

- Strong evidence supports need for and impact of BMI screening.
- Systematic review evidence from the US Preventive Services Task Force (USPSTF) supports follow-up activities with BMI screening. Updated USPSTF guidelines to be released later this year.
- Granularity of measure allows for reporting of two separate rates.
- Measure focuses on broad population; focuses on overweight and underweight adults.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: **H-3; M-6; L-1; I-0** 2b. Validity: **H-3; M-6; L-1; I-0**

<u>Rationale:</u>

- The Committee did not have significant concerns with reliability or validity.
- Additional information to explain what documentation is required for "follow-up" of BMIs outside the normal parameters would be helpful.

3. Usability: H-3; M-7; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

<u>Rationale:</u>

- Measure is currently in wide use. Used in Physician Quality Reporting System (PQRS) and HITECH programs.

4. Feasibility: H-5; M-4; L-1; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale:</u>

- Measure has been retooled for EHRs as part of meaningful use.

5. Related and Competing Measures

This measure directly competes with measure #0023: BMI in adults > 18 years of age and measure #1690: Adult BMI Assessment.

- All three measures assess BMI in adult populations; however, measure #0421 includes a follow-up component in addition to screening. (Two separate rates are reported.) The Committee believed that this granularity and inclusion of a follow-up activity supported the endorsement of this measure. (Please note that measures 0023 and 1690 did not pass Importance to Measure and Report, and were therefore not recommended for endorsement.)

0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

Steering Committee Recommendation for Endorsement: Y-10; N-0

Rationale:

- Strong evidence and current use supports the continued endorsement of this measure.

Recommendation

- Committee recommends that the measure specifications are revised when updated USPSTF recommendation are released.
- Committee recommends that exclusions regarding "refusal" and "if there are any reasons" are removed.

Public & Member Comment

Comment include:

- Recent studies suggest BMI only may not accurately reflect health risk.

  Developer response: While we recognize the additive predictive value of including other parameters such as waist circumference, as an already complex screening and follow up measure, it would make this measure too complex to try and include both BMI and waist circumference parameters. Also adding complexity is the fact that there is significant variation in waist circumference for different ethnic groups. Moving forward, however, we will consider your suggestions for possible future measure development.

- Measure would be stronger if it captures BMI score as well.

  Developer response: To provide clarity, the reporting of this measure does require the provider to distinguish between whether the BMI was normal or abnormal. If abnormal, an appropriate follow up plan must be documented based on whether the score was abnormally low or abnormally high. As more providers begin to report this measure from their electronic medical record (EMR), the EMR will report the score which will then be used in the calculation algorithm to determine if the appropriate follow up was initiated.

- The upper limit BMI cutoff should be > 30 for patients of all ages as supported by the recent evidence-based clinical guideline from the U.S. Preventive Services Taskforce (USPSTF).

  Developer response: The recent USPSTF clinical guideline states that providers should refer individuals with a BMI > 30 to intensive, multicomponent behavioral interventions. Obesity is defined as a BMI > 30. Overweight is defined in the population <65, as a BMI > 25 and < 30. In the 6th decade of life weight generally stabilizes and most adults will then lose weight with aging. In the population less than 65, however, overweight individuals have a significant risk of becoming obese. Therefore, our Technical Evaluation Panel (TEP) for this measure felt strongly that providers needed to be more proactive in this population and institute interventions to prevent eventual progression to obesity. The scope of NQF 0421 outlines calculated BMI & follow up interventions for overweight, obese and underweight populations.

Steering Committee response: The Committee accepted the developer's responses and did not change their endorsement recommendation.

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

Submission I Specifications

Status: Maintenance, Original Endorsement: August 10, 2009

Description: Percentage of children 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of body mass index (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Numerator Statement: Body mass index (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Denominator Statement: Children 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or OB-GYN.

Exclusions: Optional Exclusion: Children who have a diagnosis of pregnancy during the measurement year.

Adjustment/Stratification:

Level of Analysis: Clinician : Individual, Health Plan, Population : National

Type of Measure: Process

Data Source: Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STEERING COMMITTEE MEETING [05/30/2012]

Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-8; M-1; L-0; I-0**; Abstain-1 **1b.** Performance Gap: **H-7; M-2; L-0; I-0;** Abstain-1 **1c.** Evidence: **Y-8; N-1; Abstain-1**

Rationale:

- The Committee determined data on impact and performance gap were sufficient.
- The data presented was determined to be largely sufficient, however moderate ratings were selected by some Committee members because they were concerned that the quality of evidence and consistency descriptions presented were not entirely complete.
- Good data on differences across plans, and sufficient information presented to indicate disparities in care.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: **H-6; M-3; L-0; I-0; Abstain-1 2b.** Validity: **H-4; M-3; L-2; I-0; Abstain-1**

Rationale:

- Concern regarding under-reporting of counseling activities when utilizing billing and medical record data.
- Committee suggested it may be beneficial if specific calculations were used for percentile ranking of pediatric BMI.

3. Usability: H-5; M-4; L-0; I-0; Abstain-1

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)*

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

Rationale:

- Measure included in Child Health Insurance Program (CHIPRA) initial core set of measures and included in Final Rule Meaningful Use Measures.

4. Feasibility: H-3; M-6; L-0; I-0; Abstain-1

(*4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)*

Rationale:

- Retooled for EHRs as part of meaningful use.

5. Related and Competing Measures

- No related or competing measures noted

Steering Committee Recommendation for Endorsement: Y-8; N-1; Abstain-1

Public and Member Comment

Comments include:

- Measure should capture the BMI score.

  Developer response: While the measure does not capture an actual BMI score, it does require that a BMI percentile be documented. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

- Ensure that the age range is harmonized with the Meaningful Use measure, which defines the denominator population as 2-17 years of age.

  Developer response: The intent of this measure is to evaluate whether patients received BMI screening and physical activity/nutrition counseling between the ages of 3 and 17 years. The measure submitted for Meaningful Use calculates age according to the age of the patient at the beginning of the measurement period, whereas the measure submitted for NQF endorsement consideration, calculates age as of the end of the measurement period. The age parameters in the Meaningful Use specifications were adjusted to capture the same age group of patients across reporting program types.

- Include quantifiable data like physical activity levels achieved by the patient or time spent counseling the patient.

  Developer response: We appreciate the recommendation and will explore options for future measure development.

Steering Committee response: The Committee accepted the developer's responses and did not change their endorsement considerations; however, they strongly believed that there should be greater alignment between the age range used in the Meaningful Use measure (2-17) and the current measure under NQF endorsement consideration (3-17) in order to lessen the confusion with the measure specifications. Furthermore, the Committee agreed that assessment of BMI level is an important potential future enhancement to this measure.

0029: Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity

Submission I Specifications

Status: Maintenance, Original Endorsement: August 10, 2009

Description: Discussing Physical Activity: Percentage patients 65 years of age and older who reported: discussing their level of exercise or physical activity with a doctor or other health provider in the last 12 months

Advising Physical Activity: Percentage patients 65 years of age and older who reported receiving advice to start, increase, or maintain their level of exercise or physical activity from a doctor or other

health provider in the last 12 months

Numerator Statement: This is a patient self-reported survey measure with two rates:

a- Discussing physical activity: The number of patients in the denominator who responded "yes" to the question, "In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise."

b- Advising physical activity: The number of patients in the denominator who responded "yes" to the question, "In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program."

Denominator Statement: a- Discussing physical activity: The number of Medicare members 65 years and older as of December 31st of the measurement year who responded "yes" or "no" to the question "In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise."

b- Advising Physical activity: The number of Medicare members 65 years and older as of December 31st of the measurement year who responded "yes" or "no" to the question, "In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program."

Exclusions: N/A

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Health Plan, Population : National

Type of Measure: Process

Data Source: Patient Reported Data/Survey Medicare Health Outcomes Survey

URL http://www.hosonline.org/Content/SurveyInstruments.aspx

Measure Steward: National Committee for Quality Assurance

0029: Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity

STEERING COMMITTEE MEETING [05/30/2012]

Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-7; M-3; L-1; I-0 1b.** Performance Gap: **H-10; M-0; L-0; I-1; 1c.** Evidence: **Y-6; N-3; I-2**

Rationale:

- Evidence for importance of physical activity is high, some limitations regarding the evidence presented for the impact of counseling.
- Overall, measure demonstrates opportunity to improve health and specifically cites the 2002 USPSTF recommendations.
- USPSTF to release updated recommendation in 2012 which will likely continue to support this measure
- Data indicates significant performance gap as only 50% of patients reported physician had asked about their physical activity levels.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: **H-7; M-3; L-1; I-0; 2b.** Validity: **H-6; M-4; L-1; I-0**

Rationale:

- The Committee did not have significant concerns with reliability or validity.
- Moderate and low ratings selected by some Committee members reflect concern about the data source, particularly the response rate on the patient reported survey.

3. Usability: H-7; M-3; L-1; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

Rationale:

- Measure recently adopted by Medicare Stars program.
- Measure already in use in HEDIS reporting.

4. Feasibility: H-3; M-8; L-0; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- Slight concern regarding feasibility because data elements are collected from non-electronic patient surveys.

5. Related and Competing Measures

- No related or competing measures noted.

0029: Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity
Steering Committee Recommendation for Endorsement: Y-10; N-1 Rationale: • Reasonable process measure to understand the impact of counseling on exercise. • Measure developers should review the soon to be released USPSTF recommendations regarding counseling for physical activity.
Public & Member Comment Comment: • Revise the measure to include quantifiable data like physical activity levels achieved by patient or time spent counseling the patient, and whether or not the patient made changes to their level of physical activity. **Developer response**: We appreciate the recommendations and agree that the measure would be strengthened if it evaluated patient reported change in physical activity level. We will explore these avenues in the future. **Steering Committee response**: The Committee agreed with the developer's response and did not change their recommendation.