NATIONAL QUALITY FORUM

# Population Health Endorsement Maintenance: Phase II

DRAFT TECHNICAL REPORT FOR COMMENT

July 19, 2012

## Contents

# Population Health Endorsement Maintenance: Phase II

DRAFT TECHNICAL REPORT

## Introduction

Population health is the collective well-being and functional ability of an identified group of people to experience their full capabilities. It has multiple environmental, behavioral, social, and biological determinants. Population health is generally understood as a systems-level concept that describes health outcomes of a group of individuals that are measured through a broad spectrum of public health, clinical care, socio-economic, and physical environmental determinants that function interdependently and cumulatively. Population health not only focuses on disease and illness across multiple sectors, but also on health and wellbeing, prevention and health promotion, and disparities in such outcomes and improvement activities within a group and/or between groups. Identifying valid and reliable measures of performance across these multiple sectors can be challenging. Data collection, health assessments at individual and aggregate levels, payment structures, quality of patient care, public health interventions, and other components present challenges in shaping widespread, standardized implementation of population health measures, but overcoming these challenges is critical to any strategy to understand and improve it.

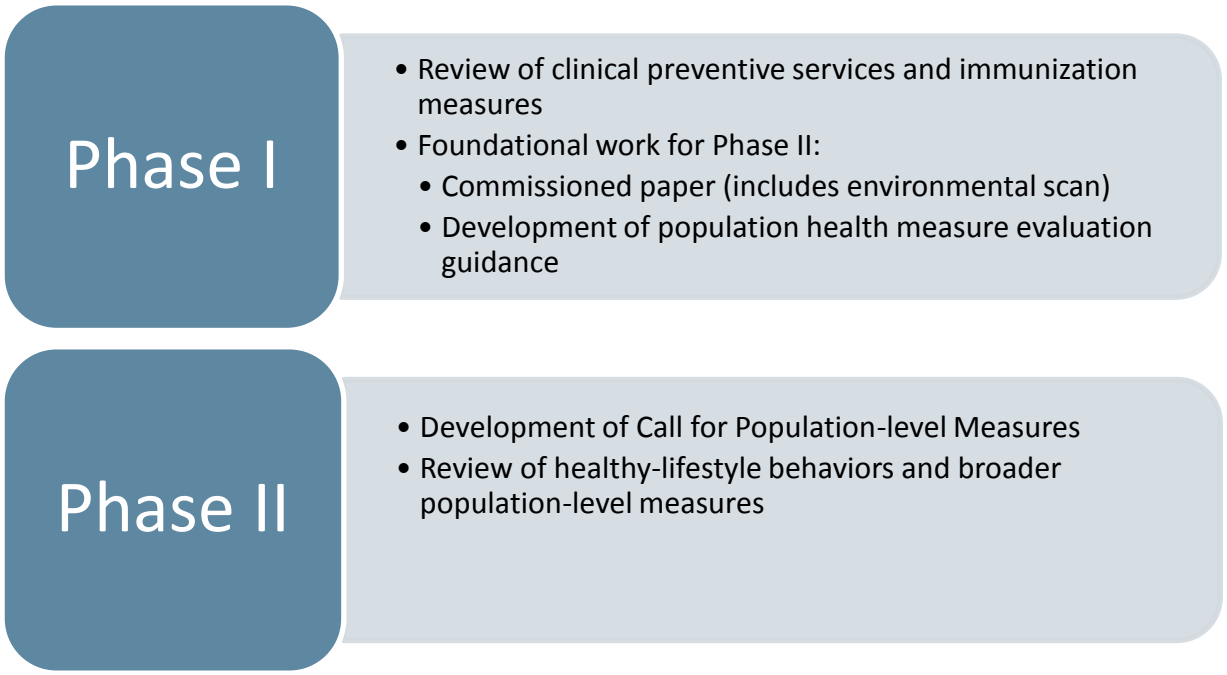
Given the multi-dimensional focus of population health, developing strategies to strengthen the measurement and analysis of population health—longitudinally and cross-sectionally—and the explanation of health outcomes for specific populations, can be best accomplished using a collaborative approach that includes public health, healthcare delivery systems, and other key sectors whose policies, practices, and procedures influence health. Social, environmental and behavioral factors can have significant negative impact on health outcomes and economic stability,[i] and these along with other upstream determinants contribute to 60 percent of U.S. deaths[ii]. Using the right measures can determine how successful initiatives are in reducing this mortality and excess morbidity and help focus future work to improve population health in appropriate areas.

Recognizing population health as a core societal value and fundamental aim of both public health and healthcare systems, the National Quality Strategy (NQS) includes three interlinked aims—better care, affordable care, and healthy people/communities. The NQF-convened National Priorities Partnership (NPP) as part of its input to the Secretary of Health and Human Services on the NQS[iii] recommended a three-tiered approach to population health to address the national priority of working with communities to promote the wide use of best practices to enable healthy living and well-being:

1. Promoting healthy living and well-being through community interventions that result in improvement of social, economic, and environmental factors.
2. Promoting healthy living and well-being through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan.
3. Promoting healthy living and well-being through receipt of effective clinical preventive services across the lifespan in clinical and community settings.

## NQF's Current Population Health Project

Although NQF has previously endorsed several population-level measures (Appendix C), the Population Health Endorsement Maintenance project is the first consensus development project primarily focused on population-level performance measures. The project was structured in two distinct phases:




In phase I, an 18-member Steering Committee with expertise in performance measurement, public, and population health evaluated clinical preventive services and immunization measures across the lifespan. In phase II, the focus of this report, the project sought population-level measures inclusive of the other two approaches from the NQS's three-tiered approach to population health, including a focus on healthy lifestyle behaviors and community interventions that improve health and well-being, as well as measures that assess modifiable social, economic, and environmental determinants of health and outcomes of populations.

Despite targeted outreach efforts, only five new measures were submitted for endorsement consideration. (Additionally, four previously-endorsed clinical body mass index (BMI) measures were under maintenance review.) This report is not limited to the Steering Committee's evaluation of nine measures, but also provides an overview of the foundational work for phase II, including the development of guidance for population health measure evaluation, a commissioned paper, and strategic discussion on improving response to future calls for population-level measures. Highlights from the strategic discussion are captured under the "Future Development" section of this report.

### *Foundational Work for Current Population Health Project*

Because this was NQF's initial project devoted specifically to population-level measures, two pieces of foundational work were undertaken before the Call for Measures and measure evaluation work were launched: review of NQF's measure evaluation criteria and development of a commissioned paper on population health measurement frameworks and environmental scan.

### Development of Evaluation Guidance for Population-level Measures

In preparation for phase II, the Steering Committee examined NQF's measure evaluation criteria and developed additional guidance and context for population-level measures. The Committee decided that the basic criteria (Importance to Measure and Report, Scientific Acceptability of Measure Properties, Usability and Feasibility) can be extended to population-level measurement, but additional guidance and context were required to address conceptual and methodological issues specific to population-level performance measurement. In short, the Committee standardized nomenclature to ensure appropriateness and comprehension of the criteria for population-level measures and to provide measure developers a standardized framework for understanding the focus of measures sought in this project.

### Commissioned Paper

NQF commissioned the Los Angeles County Department of Public Health and the Public Health institute (PHI) to develop a paper with the following goals:

- Present an environmental scan of existing measures and community health improvement priorities;
- Propose analytic frameworks for assessment and measurement of population health;
- Discuss alignment between the clinical care system and public health system;
- Outline methodological issues related to population health measure development; and
- Present overall recommendations.

The paper also addresses gap areas in community and population-level performance measurement.

NQF Members and the public were invited to submit comments on the draft commissioned paper during a 15-day comment period. Twelve comments were submitted from three organizations. A conference call was held to adjudicate submitted comments. By and large, the paper was well received by the Steering Committee, NQF Members, and the public. Please refer to the Final Commissioned Paper on the NQF website for complete details.

#### OVERVIEW OF ENVIRONMENTAL SCAN

The goals of the environmental scan were four-fold:

- To provide an integrated set of definitions from academia, the clinical care system, and government public health systems for population health, the determinants of health, and health improvement activities;
- To review existing measurement frameworks used by the clinical care and government public health systems to assess and track total population health, the determinants of health, and health improvement activities;
- To propose an integrated measurement framework that includes measures of total population health, the determinants of health, and health improvement activities; and

- To discuss the challenges with and opportunities for aligning health improvement activities and measurement across the clinical care system and the governmental public health system, in partnership with stakeholder organizations.

### DEFINITIONS

As part of the scan, the authors reviewed several definitions of population, population health, the determinants of health, and health improvement activities. The scan did not reveal a single universally-accepted definition for population health or determinants of health. The paper also includes a list of recommendations for defining key concepts along with rationale for the selected approaches.

### CONCEPTUAL MEASUREMENT FRAMEWORKS

Five conceptual frameworks for assessing and measuring total population health, the determinants of health, and health improvement activities across the clinical care and government public health system were reviewed by the paper; these frameworks are listed below. Each model describes the general relationship between determinants and outcomes and proven improvement activities.

1. *Healthy People 2020* Framework[1]
2. CMMI Measurement Framework[2]
3. Mark Friedman's "Results Accountability" Framework (as modified by the Los Angeles County Department of Public Health)[3]
4. Evans and Stoddart Field Model (as modified by David Kindig)[4]
5. IOM Logic Model for Public Health Measurement[5]

The selected frameworks are derived from an environmental scan of select national indicator reports, a representative sample of state-based and local community health improvement plans, and high priority quality improvement activities from within the clinical care and government public health system. As

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[1] Action model to achieve Healthy People 2020 overarching goals. Assesses the influence of interventions (policies, programs and information) on determinants of health and the influence of determinants on outcomes (risk factors, will-being, health equity etc.). In this model, quality improvement is a continuous process.

[2] Center for Medicare and Medicaid Innovation. Mission (modified Triple Aim). This framework places the first two aims of the Triple Aim (Better Care and Better Health) within the context of total population health outcomes.

[3] Focuses on two types of measures – total population health and improvement activities. Health determinants are represented by associated population indicators.

[4] Developed by Robert Evans and Greg Stoddart – this model links determinants of health to total population health status and health outcomes and health improvement activities (policies and programs) influence both of these domains. These integrated measures were developed for the County Health Rankings and BRFSS.

[5] Determinants of health are linked to health improvement activities (resources, processes, interventions) and intermediate and final health outcomes. The model takes into account partnerships and geographic differences in health outcomes and setting priorities.

with the definitions for population health and the determinants of health, the paper's authors failed to find consensus on a single framework that is currently in use by the both systems. They suggest that geographic variation in goals and objectives, including data availability, funding, community preferences and priorities contribute to the lack of alignment amongst these definitions and frameworks.

For several weeks, the Committee debated which framework was most comprehensive but failed to reach consensus. In the end, key attributes from each model were extrapolated and included in the Call for Measures as guidance for measure submitters.

### EXISTING POPULATION AND COMMUNITY HEALTH MEASURES

The authors developed a crosswalk of selected total population health indicator reports, community health assessments, and sample performance reports from various governmental agencies, clinical care organizations, and community and non-profit organizations. (The paper presents a comprehensive list of these indicators/measures; a few are included in Table 1 as an illustrative example.)

The findings suggest little to no synergy for determining measurement priorities between the different stakeholder groups. In many instances, funders' priorities were often elevated but did not always reflect the needs of the local constituents. The authors believe that these and other factors contribute to the significant variability in population-based survey design and questions.

**Table 1: Indicators used to access population health, determinants of health, and improvement activities** (excerpt from Commissioned Paper on Population Health)

| Concept/Domain | Indicator/Measures |
|---|---|
| **Health status/Health-related quality of life** (total population) | • Life expectancy<br>• Expected years with chronic disease |
| **Health Outcomes-Final** (total population) | • Mortality<br>• Health status and health-related quality of life |
| **Health Outcomes-Intermediate** (total population-level) | • Levels of risk behaviors (e.g. diet, physical activity, tobacco use, alcohol/drug use)<br>• Physiologic measures (e.g. controlled blood pressure or cholesterol levels) |
| **Determinants of health** | |
| Social environment | • Poverty<br>• Affordable and adequate housing |

| Concept/Domain | Indicator/Measures |
|---|---|
| Physical environment | • Built environment (transportation options, availability of healthy foods)<br>• Exposure to environmental hazards (air, water, food safety) |
| **Health improvement activities** | |
| Capacity | • EHR and integrated surveillance systems |
| Process | • Materials translated, health literacy<br>• Quality improvement projects |
| Outcomes | • Preventable hospitalizations and readmissions<br>• Patient satisfaction |

### OPPORTUNITIES FOR ALIGNMENT

The authors affirm that clinical care system priorities can be integrated with government public health system and other stakeholder organization priority areas to collectively measure and track synergistic work related to improvement in total population health outcomes and determinants of health. Leadership and communication are essential to moving population health in this direction. A number of strategic activities have or soon will prioritize stakeholder partnerships in this area, including activities through the National Prevention Council's National Prevention Strategy; the Affordable Care Act's (ACA) Community Health Benefits, which mandates that non-profit hospitals conduct comprehensive community health assessments of their service populations; and the Center for Medicare and Medicaid Innovation (CMMI), which, as one of its initiatives, provides payment incentives to the healthcare delivery system by encouraging healthy behaviors. Two specific examples of synergistic areas that have particular relevance to both phases of this NQF consensus development project are chronic disease prevention and management and delivery of clinical preventive services.

### OVERALL RECOMMENDATIONS OF THE COMMISSIONED PAPER

The authors reiterated the importance of developing and using shared definitions and conceptual frameworks within and across systems despite the challenges of competing priorities. These include the concept and definition for subpopulation and subpopulation health; health improvement activities; and the categorization of determinants of health to include genetics and individual biology, clinical care, behaviors, social environment, and physical environment. With regard to measures and measurement, the authors encourage the use and adoption of existing national indicator sets, particularly those that assess total population health, and an assessment of health equity in all population health measures submitted through the NQF process. Finally, in terms of identifying areas of synergy between the clinical health care system and public health, the authors suggest to "start small and identify overlap where complimentary health improvement activities…already exist and make buy-in and collaboration possible". They provided several potential domains and measures/indicators, including those related to

health-related behaviors that assess smoking/tobacco use, alcohol use, physical activity, and diet/nutrition.

### Development of Call for Population-level Measures

The recent Call for Population-level Measures integrated priority areas for healthy living and well-being from the NQF NPP, with particular focus on community interventions that result in improvement of social, economic, and environmental factors and interventions that result in adoption of healthy lifestyle behaviors across the lifespan. The Call included additional guidance and context for measure submitters. This guidance was largely informed by the commissioned paper and highlights attributes from the five conceptual measurement frameworks. Each depicted domains for assessing and measuring total population, determinants of health, and health improvement activities.

## Measure Evaluation

During this second phase of the Population Health project, the Steering Committee was tasked with evaluating provider and population-level measures, including those that focus on healthy lifestyle behaviors and community interventions that improve health and well-being, as well as social and economic conditions. The Population Health Steering Committee evaluated five new measures and four measures undergoing maintenance review against NQF's standard evaluation criteria, including the population health guidance as appropriate for certain measures. To facilitate the evaluation, the candidate standards were divided into two workgroups. Each Committee member was assigned to a workgroup and reviewed the measures against the sub-criteria prior to consideration by the full Steering Committee. The Committee's discussion and ratings of the criteria are summarized in the evaluation tables beginning on page 17.

POPULATION HEALTH: PHASE II SUMMARY

| | MAINTENANCE | NEW | TOTAL |
|---|---|---|---|
| **Measures under consideration** | 4 | 5 | 9 |
| **Measures withdrawn from consideration** | 0 | 1* | 1 |
| **Measures Recommended** | 3 | 2 | 5 |
| **Not recommended** | 1 | 3* | 4 |
| **Reasons for Not Recommending** | **Importance - 1**<br>**Scientific Acceptability - 0**<br>**Overall – 0**<br>**Competing measure - 0** | **Importance - 3**<br>**Scientific Acceptability - 0**<br>**Overall - 0**<br>**Competing measure - 0** | |

* A BMI assessment measure from NCQA was withdrawn following the Steering Committee's evaluation and vote. The measure was not recommended for endorsement consideration and is therefore also included in the "Not recommended" tally.

## Overarching Issues

During the Steering Committee's discussion of the measures, two overarching issues emerged that were factored into the Committee's ratings and recommendations for multiple measures and are not repeated in detail in the corresponding measure evaluation tables:

### *Level of Analysis*

There was significant discussion about the utility of measures that assess quality at the national level of analysis versus the state level of analysis. The Committee questioned what the locus of accountability would be and the incentive to drive quality improvement at the national level only, if measures cannot be drilled down to lower levels of aggregation. The Committee strongly recommends population-level measures that can be utilized and assessed at multiple levels of analysis including state, county, city, and/or community.

### *Related/Competing Measures*

The Steering Committee was tasked with evaluating three related and/or competing measures that assess body mass index (BMI) for adult populations > 18 years. Please refer to page 49 for a side-by-side comparison of these measures.

- Measure #0023: BMI in Adults > 18 years of age (City of New York Department of Health and Mental Hygiene) (maintenance)
- Measure #0421: Preventive Care and Screening: BMI Screening and Follow-up (CMS) (maintenance)
- Measure #1690: Adult BMI assessment (NCQA) (new)

The Steering Committee evaluated each measure individually using NQF's measure evaluation criteria. Neither measure #0023: BMI in Adults > 18 years of age nor measure #1690: Adult BMI assessment was determined by the Steering Committee to have met the Importance to Measure and Report criterion. Because this is a must-pass criterion, voting on these two measures stopped at this point, and these measures were not recommended for endorsement.

Although harmonization was not necessary in this instance, the Committee expressed a desire for a single BMI measure. The Committee suggested the measure should factor in the relevant populations for BMI assessment. The Committee acknowledged that the differences in data sources are a limiting factor at the present time, but a combined measure should be a goal for the near future.

## Measure Specific Issues

During the Steering Committee's discussion of the measures, several issues specific to individual measures emerged.

### *Measure Construct*

The Steering Committee raised serious concerns about the construct of two population-level measures submitted by the CDC, measure #2014: Place of birth and measure #2018: Year of arrival to the United States (for foreign born). Both submissions address an aspect of disparities related to foreign-born populations in the United States. While acknowledging that these are important determinants of health

neither is modifiable nor provides opportunities for improvement. The Committee believes that both are important demographic data elements that could be used to stratify measures that assess population health and related outcomes, modifiable determinants of health, and improvement activities/interventions. These measures were not recommended for endorsement.

### *Validity Concerns*

With regard to measure #1999: Late HIV diagnosis, the Steering Committee questioned the rationale for changing the measure specifications from diagnosis of Stage 3 HIV infection (AIDS) from within 12 months of diagnosis (an earlier iteration of the measure) to within 3 months of diagnosis. 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 associated with seeking care and availability of the first CD4 results that confirm diagnosis. The Steering Committee accepted the developer's response.

### *Standardized Survey Questions*

The Steering Committee expressed a desire for improved alignment of survey questions that assess smoking prevalence. Although the survey questions in measure #2020: Adult current smoking prevalence are harmonized with national surveys like the Behavioral Risk Factors Surveillance System (BRFSS) and the National Household Interview Survey (NHIS), they are not entirely aligned with other tobacco-related measures that assess non-combustibles and other tobacco products. The CDC will consider expansion of their tobacco prevalence questions across their surveys at a later date.

## Recommendations for Measure Development and Submission of Population-level Measures

The Committee discussed outreach for the recent Call for Measures and they, along with the measure developers, shared their views on the subsequent response. The Committee also identified several strategic opportunities for further collaboration between NQF, measure developers, existing partners and potentially new partners.

Despite targeted outreach efforts, only four population-level measures were submitted for endorsement consideration. Several potential measure submitters expressed strong interest in submitting measures through this project, however, were unable to do so because of internal resource and time constraints including,

- Overall readiness;
    - Concerns about their testing completeness or uncertainty about the testing requirements;
    - Lack of resources in terms of staffing and time to collect information and/or complete NQF's measure submission form or to complete testing; and
    - Competing organizational priorities and reduction or elimination of funds allocated for measure development.

## Perspectives on Increasing Response to Future Call for Measures

To learn more about the relatively low response to the recent Call for Measures and to exchange ideas about what can be done in the future, the Steering Committee invited measure developers to participate in a facilitated discussion about the recent Call on Day two of the in-person meeting. Peggy Honore, MD, Department of Health and Human Services, Office of the Assistant Secretary for Health, shared perspectives on her work with the Centers for Medicare and Medicaid Innovations (CMMI). She noted the inherent challenges of population health measure development, the difficulty in reaching consensus on the concept of population health, and the need for greater synergy between the clinical healthcare system and public healthcare system. Dr. Honore noted that the Center has launched a series of educational webinars and listening sessions on population health.

### *Measure Developers' Perspectives*

Peter Briss, MD, MPH, Medical Director of the National Center for Chronic Disease Prevention and Health Promotion at the CDC and Neil Maizlish, PhD, Epidemiologist, California Department of Public Health shared their thoughts on the actual and perceived barriers to submitting measures through this consensus development project, relevance of NQF-endorsed measures to their work and initiatives, and opportunities for improved engagement with measure developers.

Dr. Briss presented a synthesized view from several partners within the CDC, focusing on three main points:

- Within the CDC, there is tremendous interest and support in creating a better interface between the healthcare system and community health systems in population health;
- Current NQF evaluation criteria are appropriate for evaluating population-level measures; and
- Need for the public health community to emphasize the value add of NQF endorsement and make a convincing case for proposed uses of endorsed measures.

Dr. Briss acknowledged that many measure developers believe that the NQF process can be arduous. He noted that given the uncertainty about how the measures are likely to be used, it is difficult for people to make the return on investment case for going through the endorsement process. Dr. Briss also sounded a cautionary note about the unintended consequences of introducing payment incentives into current population or community health measurement systems.

Dr. Briss further noted the difficulties of aligning measures and ensuring coherence across surveys and programs, and shared with the audience that there is a fair amount of inter-, intra-, and cross-governmental discussion on this issue. In his view, if healthcare systems and clinicians standardized the approach to asking health behavior questions, it will enable more opportunities for rolling up and down measurement efforts from the individual provider-level to the healthcare system level, to the community-level and further down.

Dr. Maizlish shared some of the barriers that prevented his organization from submitting measures in a letter prior to the in-person meeting and during the meeting including:

- Timing of the project; and

- Proprietary concerns with some of their data.

Contributing to the Committee's discussion about the readiness of local and state entities to develop measures that assess upstream determinants of health, Dr. Maizlish stated that several communities like those in Jacksonville, Florida and Santa Cruz, California have been conducting this work for quite some time. For example in California, many local health departments have adopted a conceptual framework that examines upstream conditions and presents an entire continuum from institutional power and structural racism and economic activities, and their effect on basic living conditions of populations and individual behaviors, risk factors, and morbidity and mortality outcomes. According to Dr. Maizlish, several of these entities are aligning with non-traditional partners to address climate change and other social and environmental factors and their effect on overall population health. Dr. Maizlish agreed that greater standardization of survey and other measurement tools is urgently needed.

Finally, representatives from the Health Resources and Services Administration (HRSA) contributed to the discussion and explained that timing and lack of resources played a part in their inability to submit measures through this project. Additionally, some proposed measures from the maternal and child health and HIV/AIDS bureaus were not tested and validated by the submission deadline. HRSA also cited the short submission deadline and relative inexperience of some of the Agency's measure development teams as additional barriers to submission.

### *Steering Committee's Perspective*

The Steering Committee approached the low response to the recent Call for Measures more broadly. First, they outlined specific issues related to the Call; developed a subset of strategic priorities; created a list of desired future measures; and proposed initial next steps for the Committee, NQF staff, and its leadership. The Committee's recommendations not only challenge NQF to leverage its position in healthcare quality in a manner that resonates with the public health community and their performance priorities, but also challenges clinical care organizations, governmental agencies, and the public health community to think about transformative approaches to collaborative partnerships. It is important to note that while this rich exchange of ideas has been summarized, NQF is assessing the feasibility of the Committee's proposals. Many present significant resource and other important considerations and require input from NQF's Board of Directors, Consensus Standards Approval Committee (CSAC), and HHS; therefore, a prioritized list and specific action plans would be premature at this stage of planning.

#### Identifying Issues Related to the Low Response to the Recent Call for Measures

The Steering Committee cited four major issues associated with the recent Call for Measures:

1. Low volume of submitted measures
2. Quality of measures and level of analysis
    a. Measures, including those under maintenance review, were primarily clinically-focused.
    b. None addressed upstream determinants of health.
3. Arduous submission process and confusion around the evaluation process
    a. Several developers expressed frustration about the submission process.
    b. Due to timing and other constraints, online submission forms were not updated to reflect the Committee's guidance for evaluating population-level measures, although the material was available as attachments or supplemental guidance.

4. Lack of clarity about the value proposition of NQF endorsement for public and community health organizations

### Strategic Recommendations for Improving Future Call for Measures

1. **Identify other population-level measures in use and potential partners.**
    a. Conduct a collaborative analysis (or environmental scan) of potential partners involved in population health indicator/measure development. These partners might offer an opportunity to work in the synergistic areas described in the commissioned paper and discussed by the Committee during the May 2012 in-person meeting. Following the analysis, NQF is encouraged to conduct targeted outreach to identified potential partners. Potential partners included academic partners (e.g., University of Wisconsin); funding partners (e.g., CDC, HRSA), and public/community health partners (e.g., American Public Health Association (APHA), Council of State and Territorial Epidemiologists (CSTE), and the Community Indicators Consortium).

2. **Refine the guidance and definitions provided to developers and the Steering Committee.** The Committee proposed several suggestions for NQF, including:
    a. Revise the current measure submission form and related evaluation form by integrating the Committee's guidance, appropriate definitions, and references for population health; and
    b. Provide specific examples of well-specified measures ("what good looks like").

3. **Reduce the submission burden for measure developers.** Opportunities for improvement include:
    a. NQF's 2-stage CDP (currently in the pilot phase) – Through this new process, measure submitters will be able to introduce measure concepts first without the requirement for detailed specifications and measure testing. If the concept is approved, the developer can submit a fully specified, tested measure within 18 months. Public and community health partners would benefit from early feedback on their submissions and additional time to prepare testing data.
    b. Provide detailed technical support that will enable shared learning between non-traditional submitters (i.e., from public and community health) and NQF.
    c. Establish interactive community forums or portals for developers with different levels of familiarity with NQF's processes that will foster bi-directional learning and sharing.
        i. Encourage "traditional" NQF measure developers to think outside the "clinical care box" and partner with community and public health organizations to develop measures.

4. **Consider the value preposition for NQF endorsement of population health measures.**
    a. **Key questions include:** What are the benefits to population health measure developers? What are the benefits to the broader public, community health system? Who are the users and what are the intended uses of NQF-endorsed measures?
    b. Identify the intersections between the healthcare delivery system and public health system. As recommended in the commissioned paper, areas of synergy where complementary health improvement activities already exist increase the likelihood of buy-in and collaboration within and between resource strapped systems. Suggested starting points and opportunities to explore further are:
        i. Health behaviors measures that assess diet, smoking and tobacco use, alcohol use and physical activity; the commissioned paper cited this domain and measure/indicator topics among the most common used to assess total population health, the determinants of health, and health improvement activities across a representative sample of clinical care, public and community health organizations.
        ii. Community Health Needs Assessments – presents an opportunity to redefine hospitals' role in relation to community health needs assessment.
        iii. Office of the National Coordinator for Health Information Technology– developing a series of population health measures for meaningful use Stage 3 for 2015.
        iv. Health Risk Assessment for Medicare Annual Wellness Visits.
    c. Identify the potential uses and users of NQF-endorsed measures
        i. Assessment of current/traditional customers (i.e. HHS and other governmental agencies) and their needs.
        ii. Build identity of non-traditional measure stewards/developers – be explicit about the role of measure steward/developer in the NQF process.
        iii. Consider expansion of customer base to state governmental agencies.
        iv. Emphasize the value of harmonization and standardization of measures and definitions. For example, if measures in the above domain (health behaviors) were standardized or harmonized with measures that the clinical care delivery system is gathering for subpopulations, then these could be rolled up and down to attain total population measures. These measures may drive improvement activities in the healthcare system and measurement and assessment of upstream social and environmental determinants.

### Desired Future Measures

In addition to proposing strategic approaches to increase the response to future calls for measures, the Committee expressed a desire for several types of measures including individual process and outcome measures; measures that assess upstream social, economic and environmental determinants of health; population-level blood pressure screening measures for the Million Hearts Campaign; and

comprehensive measures, like composites that take into account process, outcome, access, structure, population experience, population management, population costs, and population services.

## Measure Evaluation Summary

### Measures recommended



### Measures not recommended



### Measures withdrawn from consideration

## Measures Recommended

### 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**

## 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.

**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?

## 2020: Adult Current Smoking Prevalence

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.

**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.

### 2020: Adult Current Smoking Prevalence

**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.

Recommendation:

- The Steering Committee encourages harmonization with NCQA's measure #0027 Medical assistance with smoking and tobacco use cessation if possible.

### 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: The measure meets the Importance criteria.**

(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**

Rationale:

- 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: The measure meets the Scientific Acceptability criteria.**

(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**

Rationale:

- 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)

Rationale:

- 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)

Rationale:

- 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.)

**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.

## 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)*

Rationale:

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

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

**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**

### 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: <u>The measure meets the Importance criteria.</u>**

(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**

<u>Rationale:</u>

- 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: <u>The measure meets the Scientific Acceptability criteria.</u>**

(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**

<u>Rationale:</u>

- 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)*

<u>Rationale:</u>

- 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)*

<u>Rationale:</u>

- 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.

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

<u>Rationale:</u>

- 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.

## Measures Not Recommended

### 2014: Place of Birth

**Submission**

**Status:** New Submission

**Description:** Place of birth idenfies if respondent has been born in the United States or outside the United States. People born outside the United States are asked to report their place of birth according to current international boundaries.

**Numerator Statement:** Number of respondents or patients by place of birth.

**Denominator Statement:** Total number of respondents or patients

**Exclusions:** Place of birth can be used to stratify health outcomes, access to care and other measures by U.S versus foreign born individuals. If enough sample size is available, stratification could be done by indivisual countries of birth

**Adjustment/Stratification:** Place of birth can be used to stratify health outcomes, access to care and other measures by U.S versus foreign born individuals. If enough sample size is available, stratification could be done by indivisual countries of birth

**Level of Analysis:** Population : Community, Population : County or City, Population : National, Population : Regional, Population : State Regional

**Type of Measure:** Patient Engagement/Experience

**Data Source:** Other Although several national data sources collect place of birth information, we would propose the American Community Survey as the main data source and data collection instrument

URL http://www.census.gov/acs/www/methodology/questionnaire_archive/ URL http://www.census.gov/acs/www/data_documentation/data_main/

**Measure Steward:** CDC

**STEERING COMMITTEE MEETING [05/30/2012]**

**Importance to Measure and Report: The measure does not meet the Importance criteria.**

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

**1a.** Impact: **H-0; M-3; L-6; I-1**; **1b.** Performance Gap: **H-0; M-1; L-6; I-3 1c.** Evidence: **Y-1; N-4; I-5**

Rationale:

- Place of birth is an important assessment of disparities, but in and of itself is not a modifiable measure that can demonstrate opportunities for improvement. This data element can used to stratify measures that assess population health and related outcomes, modifiable determinants of health, and improvement activities/interventions.

**Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

## 2018: Year of arrival to the United States (for the foreign born)

**Submission**

**Status:** New Submission

**Description:** Percentage of foreign born residents by number of years living in the U.S.

This measure provides information on the year when a foreign born individual came to live to the United States. The main purpose is to calculate duration of residence in the U.S

**Numerator Statement:** Number of foreign born patients, clients or respondents by year of arrival to live in the U.S.

**Denominator Statement:** Total number of foreign born patients, clients or respondents

**Exclusions:** None

**Adjustment/Stratification:** Any health outcome, behavior and access to care measure could be stratified by duration of stay (or residence) in the U.S. Duration of stay can be calculated by subtracting the "year of arrival" from the current year or year of data collection

**Level of Analysis:** Clinician : Individual, Facility, Health Plan, Population : Community, Population : County or City, Population : National, Population : Regional, Population : State

**Type of Measure:** Patient Engagement/Experience

**Data Source:** Other US Census Bureau American Community Survey

URL http://www.census.gov/acs/www/methodology/questionnaire_archive/ URL http://www.census.gov/acs/www/data_documentation/data_main/

**Measure Steward:** CDC

**STEERING COMMITTEE MEETING [05/30/2012]**

**Importance to Measure and Report: The measure does not meet the Importance criteria.**

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

**1a.** Impact: **H-0; M-3; L-6; I-1**; **1b.** Performance Gap: **H-0; M-1; L-8; I-1 1c.** Evidence: **Y-0; N-8; I-2**

Rationale:

Determining the length of stay in the United States of foreign born population is an important assessment of disparities, but in and of itself is not a modifiable measure that can demonstrate opportunities for improvement. This data element can used to stratify measures that assess population health and related outcomes, modifiable determinants of health, and improvement activities/interventions.

**Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

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

**Submission**

**Status:** Maintenance, Original Endorsement: August 10, 2009

**Description:** Percentage of adults 18 years old or older with valid BMI documentation in the past 24 month.

**Numerator Statement:** Adults 18 years old or greater with BMI documented in the past 24 months.

**Denominator Statement:** Total number of patients 18 years old or greater seen in the measurement period.

**Exclusions:** Providers can exclude patients based on medical reason, patient reason, or systemic reason.

**Adjustment/Stratification:**

**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Population : County or City, Population : Regional

**Type of Measure: Process**

**Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

**Measure Steward:** City of New York Department of Health and Mental Hygiene

**STEERING COMMITTEE MEETING [05/30/2012]**

**Importance to Measure and Report: The measure does not meet the Importance criteria.**

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

**1a.** Impact: **H-5; M-4; L-1; I-0**; **1b.** Performance Gap: **H-8; M-2; L-0; I-0 1c.** Evidence: **Y-4; N-2; I-4**

Rationale:

- While BMI is currently considered the best clinical tool for measuring adiposity, the measure submission did not adequately support this information. The measure developer failed to utilize the most current studies to support the evidence for this measure.
- Clinical practice guideline citation is incomplete/inaccurate.
- Question about the benefit of measuring and reporting BMI without counseling/recommendations when patients are outside "normal" parameters.

**Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

## 1690: Adult BMI Assessment

**Submission**

**Status:** New Submission

**Description:** The percentage of adults 18–74 years of age who had body mass index (BMI) documented

**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.

**Denominator Statement:** Adults 18-74 years of age who had an outpatient visit

**Exclusions:** Optional Exclusion: Adults who have a diagnosis of pregnancy during the measurement year or the year prior

**Adjustment/Stratification:** N/A

**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Health Plan, Population : National

**Type of Measure: Process**

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

**Measure Steward:** National Committee for Quality Assurance

**STEERING COMMITTEE MEETING [05/30/2012]**

**Importance to Measure and Report: The measure does not meet the Importance criteria.**

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

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

Rationale:

- Evidence for impact of obesity is high
- Evidence for importance and impact of measuring BMI alone (without intervention) is low.
- Insufficient disparities data.

**Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

**POST STEERING COMMITTEE MEETING**

Following the May 30-31 in-person meeting, the developer requested that this measure be withdrawn citing the following reason: NCQA respectfully asks to withdraw measure #1690. NCQA carefully considered our discussions with Population Health Steering Committee. When the USPSTF releases the updated recommendations for screening obesity in adults, we will re-evaluate our measure in the light of this new evidence. Following our re-evaluation, we plan to submit this measure to NQF during the next available call for standards.

## Measures Withdrawn from consideration

One measure was withdrawn following the Steering Committee's evaluation.

- **1690: Adult BMI Assessment**

## Appendix A: Measure Specifications

| | 1999 Late HIV Diagnosis |
|---|---|
| Status | Member and Public Commenting |
| Steward | Centers for Disease Control and Prevention |
| Description | Percentage of persons 13 years and older diagnosed with Stage 3 HIV infection (AIDS) within 3 months of a diagnosis of HIV infection. |
| Type | Outcome |
| Data Source | Other National HIV Surveillance System |
| Level | Population : State |
| Setting | |
| Numerator Statement | Persons in denominator statement with a diagnosis of Stage 3 HIV infection (AIDS) within 3 months of diagnosis of HIV infection |
| Numerator Details | **Time Window:** Persons diagnosed with HIV during specified calendar year and with Stage 3 HIV infection (AIDS) within the subsequent 3 month period.<br>Information is obtained from the National HIV surveillance System. To allow for delays in reporting of HIV and of AIDS diagnoses, cases reported through the end of calendar year following the diagnosis year are included. In addition, standard adjustment for reporting delay is performed .(Song R, Hall HI, Frey R. Uncertainties associated with incidence estimates of HIV/AIDS diagnoses adjusted for reporting delay and risk redistribution. Stat med 2005;24:453-464). |
| Denominator Statement | Persons age 13 years and older diagnosed with HIV during specified calendar year. |
| Denominator Details | **Time Window:** Persons age 13 years and older diagnosed with HIV during specified calendar year.<br>Information is obtained from the National HIV surveillance System. To allow for delays in reporting of HIV diagnoses, cases reported through the end of calendar year following the diagnosis year are included. In addition, standard adjustment for reporting delay is performed .(Song R, Hall HI, Frey R. Uncertainties associated with incidence estimates of HIV/AIDS diagnoses adjusted for reporting delay and risk redistribution. Stat med 2005;24:453-464) |
| Exclusions | Persons with month of diagnosis missing are excluded (<0.05%) |
| Exclusion details | Month of HIV diagnosis = missing |
| Risk Adjustment | Stratification by risk category/subgroup<br>NA |
| Stratification | 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). |
| Type Score | Rate/proportion better quality = lower score |

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| Algorithm | • Based on HIV cases reported through the end of 2011, determine the number of HIV diagnoses in 2010(denominator)<br>• Among HIV diagnoses made in 2010, determine the number reported as having stage 3 HIV infection (AIDS) diagnosis within 3 months of HIV diagnosis, based on cases reported through the end of 2012(numerator).<br>• Numerator/denominator x 100 = percent late HIV diagnoses<br>• Note: data are adjusted for reporting delay according to standard methods (Song R, Hall HI, Frey R. Uncertainties associated with incidence estimates of HIV/AIDS diagnoses adjusted for reporting delay and risk redistribution. Stat med 2005;24:453-464) |
| Copyright / Disclaimer | Not applicable (government entity)<br>The measure specifications and supporting documentation are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention. |

| | 2020 Adult Current Smoking Prevalence |
|---|---|
| Status | Member and Public Commenting |
| Steward | Center for Disease Control and Prevention/Legacy |
| Description | Percentage of adult (age 18 and older) U.S. population that currently smokes. |
| Type | Structure |
| Data Source | Other NHIS. Please see:<br>ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2010/srvydesc.pdf<br>URL<br>ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2010/English/qadult.pdf<br>URL<br>ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2010/English/qadult.pdf |
| Level | Population : National |
| Setting | Other publilc health policy |
| Numerator Statement | The numerator is the current adult smokers(age 18 and older) in the U.S. |
| Numerator Details | **Time Window:** The time period for current tobacco use is defined by survey respondents who endorse that they "NOW smoke cigarettes every day or some days."<br>The survey is conducted annually, so new estimates of prevalence are available each year.<br>The numerator, Adult Current Smoking, is a measure collected by means of the National Health Interview Survey (NHIS), a multi-purpose health survey conducted by the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC). The NHIS is the principal source of information on the health of the civilian, noninstitutionalized, household population of the United States. The NHIS has been conducted continuously since its beginning in 1957. Public use microdata files are released on an annual basis.<br>The survey is conducted among the adult (age 18 and older) U.S. civilian, noninstitutionalized population, and is weighted to U.S. census data so that it is nationally representative.<br>The measure is composed of two survey items, both of which respondents must endorse in order to be considered current smokers (below). This measure of current smoking has been used 1997. See this NHIS document for details:<br>ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2010/srvydesc.pdf<br>Question ID: AHB.010_00.000 Instrument Variable Name: SMKEV QuestionnaireFileName: Sample Adult<br>QuestionText: These next questions are about cigarette smoking.<br>Have you smoked at least 100 cigarettes in your ENTIRE LIFE?<br>1 Yes<br>2 No<br>7 Refused<br>9 Don´t know<br>UniverseText: Sample adults 18+<br>Question ID: AHB.010_00.000 Instrument Variable Name: SMKEV QuestionnaireFileName: Sample Adult |

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| | QuestionText: These next questions are about cigarette smoking.<br>Do you now smoke every day, some days, or not at all (asked of those who smoked 100 cigarettes in the above question)?<br>(every day, some days, not at all, refused, don't know)<br>UniverseText: Sample adults 18+<br>The U.S. Census Bureau, under a contractual agreement, is the data collection agent for the National Health Interview Survey. NHIS data are collected through a personal household interview by Census interviewers. Nationally, the NHIS uses about 750 interviewers, trained and directed by health survey supervisors in the 12 U.S. Census Bureau Regional Offices. The supervisors responsible for the NHIS are career Civil Service employees who are selected through an examination and testing process. Interviewers (also referred to as Field Representatives, or "FRs") receive thorough training on an annual basis in basic interviewing procedures and in the concepts and procedures unique to the NHIS. |
| Denominator Statement | The adult (age 18 and older) population of the U.S. |
| Denominator Details | **Time Window:** The NHIS is conducted annually, so the denominator time window is one year.<br><br>The National Health Interview Survey (NHIS)is a multi-purpose health survey conducted by the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC) and is the principal source of information on the health of the civilian, noninstitutionalized, household population of the United States. The NHIS has been conducted continuously since its beginning in 1957. Public use microdata files are released on an annual basis.<br>The survey is conducted among the adult (age 18 and older) U.S. civilian, noninstitutionalized population, and is weighted to U.S. census data so that it is nationally representative. |
| Exclusions | Persons serving in the military.<br>Persons who are institutionalized. |
| Exclusion details | The survey is conducted among the adult (age 18 and older) U.S. civilian, noninstitutionalized population, and is weighted to U.S. census data so that it is nationally representative. |
| Risk Adjustment | No risk adjustment or risk stratification<br>Not applicable |
| Stratification | The NHIS Core questionnaire items were revised every 10-15 years, with the last major revisions occurring in 1982 and in 1997. The NHIS that was fielded from 1982-1996 consisted of two parts: (1) a set of basic health and demographic items (known as the Core questionnaire) that remained stable from one survey year to the next, and (2) one or more sets of questions on current health topics that varied with each survey, referred to as Supplements. Despite periodic revisions to the Core questionnaire, Supplements played an increasingly important role in the survey as a means of enhancing topic coverage in the Core. Eventually, certain Supplements, such as "Family Resources" and "Health Insurance," were incorporated in the NHIS Core on an annual basis.<br>The redesigned NHIS introduced in 1997 consists of a Basic Module or Core as well as variable Supplements. The Basic Module, which remains largely unchanged from year to year, consists of three components: the Family Core, the Sample Child Core, and the Sample Adult Core. The Family Core component collects information on everyone in the family, and its sample also serves as a sampling frame for additional integrated surveys, as needed. Information collected for all family members includes: household composition and socio-demographic characteristics, tracking information, information for linkage to administrative data bases, and basic indicators of health status, activity limitations, injuries, health insurance coverage, and access to and utilization of health care services.<br>From each family in the NHIS, one sample child (if any children under age 18 are present) and one sample adult are randomly selected, and information on each is collected with the Sample Child Core and the Sample Adult Core questionnaires. Because some health issues are different for |

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| | children and adults, these two questionnaires differ in some items, but both collect basic information on health status, health care services, and behavior. These sections of the survey yield the Sample Child and Sample Adult data files.<br>The Family Core yields several data files, including the Household-Level file, the Family-Level file, the Person-Level file, and two data files pertaining to injuries and poisonings. Because these files contain the same or comparable variables from one survey year to the next, they are suitable for trend analysis; moreover, multiple years of these data may be easily pooled to increase the sample size for analytic purposes. |
| Type Score | Rate/proportion better quality = lower score |
| Algorithm | Simple prevalence estimate in which the number of adult current smokers is divided by the adult population. URL<br>ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2010/srvydesc.pdf |
| Copyright / Disclaimer | NA<br>NA |

| | 0024 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents |
|---|---|
| Status | Public and Member Commenting |
| Steward | National Committee for Quality Assurance |
| 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. |
| Type | Process |
| Data Source | Paper Medical Records 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)<br>URL http://www.ncqa.org/tabid/370/default.aspx |
| Level | Clinician : Individual, Health Plan, Population : National |
| Setting | Ambulatory Care : Clinician Office/Clinic |
| Numerator Statement | Body mass index (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year. |
| Numerator Details | **Time Window:** The measurement year (12 month calendar year).<br>ADMINISTRATIVE SPECIFICATION:<br>BMI percentile: BMI percentile during the measurement year as identified by the following code.<br>ICD-9 Diagnosis: V85.5<br>Counseling for Nutrition: Counseling for nutrition during the measurement year as identified by the following codes.<br>CPT: 97802-97804<br>ICD-9 Diagnosis: V65.3<br>HCPCS: G0270, G0271, S9449, S9452, S9470<br>Counseling for Physical Activity: Counseling for physical activity during the measurement year as identified by the following codes.<br>ICD-9 Diagnosis: V65.41<br>HCPCS: S9451<br>MEDICAL RECORD SPECIFICATION:<br>BMI Percentile: BMI percentile during the measurement year Documentation must include height, weight and BMI percentile during the measurement year. Either of the following meets criteria for BMI percentile.<br>• BMI percentile, or<br>• BMI percentile plotted on age-growth chart<br>For members who are younger than 16 years of age on the date of service, only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria. A BMI value is not acceptable for this age range.<br>For adolescents 16–17 years on the date of service, documentation of a BMI value expressed as kg/m2 is acceptable.<br>Counseling for Nutrition: Documentation of counseling for nutrition or referral for nutrition |

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| | education during the measurement year. Documentation must include a note indicating the date and at least one of the following.<br>• Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)<br>• Checklist indicating nutrition was addressed<br>• Counseling or referral for nutrition education<br>• Member received educational materials on nutrition<br>• Anticipatory guidance for nutrition<br>Counseling for Physical Activity: Documentation of counseling for physical activity or referral for physical activity during the measurement year. Documentation must include a note indicating the date and at least one of the following.<br>• Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation)<br>• Checklist indicating physical activity was addressed<br>• Counseling or referral for physical activity<br>• Member received educational materials on physical activity<br>• Anticipatory guidance for physical activity |
| Denominator Statement | Children 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or OB-GYN. |
| Denominator Details | **Time Window:** The measurement year (12 months).<br>Ages: 3-17 years as of December 31 of the measurement year.<br>Event/diagnosis: An outpatient visit with a PCP or an OB/GYN during the measurement year.<br>Codes to identify outpatient visits:<br>CPT: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411,99412, 99420, 99429, 99455, 99456<br>ICD-9-CM Diagnosis: V202., V70.0 V70.3, V70.5, V70.6, V70.8. V70.9<br>UB Revenue: 051x, 0520-0523, 0526-0529, 0982, 0983 |
| Exclusions | Optional Exclusion: Children who have a diagnosis of pregnancy during the measurement year. |
| Exclusion details | Codes to identify Exclusions<br>ICD-9-CM Diagnosis codes 630-679, V22, V23, V28 |
| Risk Adjustment | No risk adjustment or risk stratification |
| Stratification | The total population is stratified by age: 3-11 and 12-17 years of age. |
| Type Score | Rate/proportion  better quality = higher score |
| Algorithm | 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 enrollement requirement.<br>Step 2. Search administrative systems and pharmacy data to identify numerator events for all members in the eligible population.<br>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.<br>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.<br>Step 5. Calculate the rate. |
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| | Washington, DC 20005 |

| | 0029 Counseling on Physical Activity in Older Adults – a. Discussing Physical Activity, b. Advising Physical Activity |
|---|---|
| Status | Public and Member Commenting |
| Steward | National Committee for Quality Assurance |
| 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<br>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<br>health provider in the last 12 months |
| Type | Process |
| Data Source | Patient Reported Data/Survey Medicare Health Outcomes Survey<br>URL http://www.hosonline.org/Content/SurveyInstruments.aspx |
| Level | Health Plan, Population : National |
| Setting | Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Ambulatory Care : Outpatient Rehabilitation, Ambulatory Care : Urgent Care, Behavioral Health/Psychiatric : Inpatient, Behavioral Health/Psychiatric : Outpatient, Dialysis Facility, Emergency Medical Services/Ambulance, Home Health, Hospice, Hospital/Acute Care Facility, Imaging Facility, Laboratory, Pharmacy, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility |
| Numerator Statement | This is a patient self-reported survey measure with two rates:<br>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."<br>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." |
| Numerator Details | **Time Window:** Measurement year (one calendar year)<br>This measure is collected through the Medicare Health Outcomes Survey - a national survey of Medicare Advantage Organization members. The survey is collected through mail with a telephone follow up. The two rate for this measure are collected through the following questions.<br>Discussing physical activity: Response of "yes" to Q46 in the Medicare Health Outcomes Survey (HOS):<br>"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."<br>Advising physical activity: Response of "yes" to Q47 in the Medicare Health Outcomes Survey (HOS):<br>"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 |

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| | 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."<br>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." |
| Denominator Details | **Time Window:** Measurement year (one calendar year)<br>Medicare members age 65 and above who reported having had a visit to a health care provider in the past 12 months. |
| Exclusions | N/A |
| Exclusion details | N/A |
| Risk Adjustment | No risk adjustment or risk stratification |
| Stratification | N/A |
| Type Score | Rate/proportion better quality = higher score |
| Algorithm | Step 1: Identify the eligible population (Medicare members aged 65 plus)<br>Step 2: Identify the denominator (Members responding "yes" or "no" to the question; members responding "I had not visit in the past 12 months are not included in the denominator)<br>Step 3: Identify the numerator (Members in the denominator responding yes to the questions)<br>Step 4: Rate is calculated by dividing the numerator by the denominator |
| Copyright / Disclaimer | © 2012 by the National Committee for Quality Assurance<br>1100 13th Street, NW, Suite 1000<br>Washington, DC 20005<br>No changes have been made to this measure |

| | 0421 Preventive Care and Screening: Body Mass Index (BMI) |
|---|---|
| Status | Public and Member Commenting |
| Steward | Centers for Medicare and Medicaid Services **Other organizations:** Thomas Jefferson University School of Population Health<br>ALPS Sevices Inc. |
| 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<br>Normal Parameters: Age 65 years and older BMI > = to 23 and <30<br>Age 18 – 64 years BMI > = to 18.5 and <25 |
| Type | Process |
| Data Source | Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Medical Records Medicare Part B Claims Data is provided for testing purposes. This measure is also EHR retooled. Per NQF permission, the feasibility, reliability & validity testing results will be provided with the 2013 annual measure update.<br>URL Please see attached "PQRS_128_NQF_0421_PartB_claims_AdHocRecordLayout" document on page 44 of "NQF_0421_Endorsement_Quality_Insights_of_Pennsylvania.pdf". Attachment error noted. n/a URL Please see attached "2012 Specification Coding" AND "2009 Specification Coding" on pages 27-41 of "NQF_0421_Endorsement_Quality_Insights_of_Pennsylvania.pdf". Attachment error noted. n/a |
| Level | Clinician : Group/Practice, Clinician : Individual, Population : County or City, Population : National, Population : Regional, Population : State |
| Setting | Ambulatory Care : Clinician Office/Clinic, Ambulatory Care : Outpatient Rehabilitation, Behavioral Health/Psychiatric : Outpatient, Home Health, Other Dental & Domicilliary Care |
| Numerator Statement | ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.<br>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 |
| Numerator Details | **Time Window:** This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. BMI measured and documented in the medical record may be reported if done in the provider's office/facility or if BMI calculation within the past six months is documented in outside medical records obtained by the provider. The documentation of a follow up plan should be based on the most recent calculated BMI.<br>For the purposes of calculating performance, the Numerator (A) is defined by providers reporting the clinical quality action was performed. For this measure, performing the clinical quality action is numerator HCPCS G8420, G8417 & G8418. All discussed coding detail is listed in ´2a1.7. Denominator Details" section below. |
| Denominator Statement | ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.<br>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. |

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| Denominator Details | **Time Window:** All patients aged 18 years and older at the time of the encounter seen during the 12 month reporting period.<br>The Total Denominator Population (TDP) is defined with the following criteria: 1) patient´s age at the time of the encounter 2) encounter date within the 12 month reporting period 3) denominator CPT or HCPCS encounter codes AND 4) provider reported HCPCS numerator clinical quality code described below (G8420, G8417, G8418, G8422, G8421 & G8419).<br>TOTAL DENOMINATOR POPULATION<br>Patients aged 18 years and older on the date of the encounter<br>AND<br>Patient encounters during the 12 month reporting period with the following CPT or HCPCS encounter codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0270, G0271, G0402, G0438, G0439<br>AND<br>Patient encounters with the following HCPCS numerator clinical quality codes: G8420, G8417, G8418, G8422, G8421 & G8419<br>HCPCS NUMERATOR CLINICAL QUALITY CODES (6)<br>PERFORMANCE PASS CLINICAL QUALITY CODES (3)<br>BMI Calculated as Normal, No Follow-Up Plan Required<br>G8420: Calculated BMI within normal parameters and documented<br>BMI Calculated Above Upper Normal Parameters, Follow-Up Documented<br>G8417: Calculated BMI above the upper parameter and a follow-up plan was documented in the medical record<br>BMI Calculated Below Lower Normal Parameters, Follow-Up Documented<br>G8418: Calculated BMI below the lower parameter and a follow-up plan was documented in the medical record<br>DENOMINATOR EXCLUSION (B) CLINICAL QUALITY CODE (1)<br>BMI not Calculated, Patient not Eligible/not Appropriate<br>G8422: Patient not eligible for BMI calculation<br>PERFORMANCE FAILURE CLINICAL QUALITY CODES (2)<br>BMI not Calculated, Reason not Specified<br>G8421: BMI not calculated<br>BMI Calculated Outside Normal Parameters, Follow-Up Plan not Documented, Reason not Specified<br>G8419: Calculated BMI outside normal parameters, no follow-up plan documented in the medical record |
| Exclusions | ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.<br>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:<br>There is documentation in the medical record that the patient is over or under weight and is being managed by another provider<br>If the patient has a terminal illness-life expectancy is 6 months or less<br>If the patient is pregnant<br>If the patient refuses BMI measurement<br>If there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate |

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| | 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. |
| Exclusion details | Denominator Exclusions (B) are identified with the following provider reported HCPCS numerator clinical quality code:<br>BMI not Calculated, Patient not Eligible/not Appropriate<br>G8422 Patient not eligible for BMI calculation<br>DENOMINATOR EXCLUSION CALCULATION:<br>Denominator Exclusions (B)(G8422)/Total Denominator Population (TDP)(G8420, G8417, G8418, G8421, G8419 & G8422) |
| Risk Adjustment | No risk adjustment or risk stratification<br>n/a<br>URL n/a n/a |
| Stratification | No stratification. All eligible patients are subject to the same numerator criteria. |
| Type Score | Rate/proportion better quality = higher score |
| Algorithm | THIS SECTION PROVIDES DEFINITIONS & FORMULAS FOR THE NUMERATOR (A), TOTAL DENOMINATOR POPULATION (TDP), DENOMINATOR EXCLUSIONS (B) CALCUATION & PERFORMANCE DENOMINATOR (PD) CALCULATION.<br>NUMERATOR (A): HCPCS Clinical Quality Codes G8420, G8417 & G8418<br>TOTAL DENOMINATOR POPULATION (TDP): Patient aged 18 years and older on the date of the encounter of the 12-month reporting period, with denominator defined encounter codes & Medicare Part B Claims reported HCPCS Clinical Quality Codes G8420, G8417, G8418, G8422, G8421 & G8419<br>DENOMINATOR EXCLUSION CALCULATION:<br>Denominator Exclusion (B): # of patients with valid exclusions<br># G8422 / # TDP<br>PERFORMANCE DENOMINATOR CALCULATION:<br>Performance Denominator (B): Patients meeting criteria for performance denominator calculation<br># A / (# TDP - # B) URL n/a Please see attached "NQF 0421 Endorsement - Quality Insights of Pennsylvania 050112" document on page 46. Attachment error noted. |
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## Appendix B: Project Steering Committee and NQF Staff

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## Appendix C: Measures Endorsed in Population Health

| NQF Number | Title | Steward |
|---|---|---|
| **0272** | Diabetes Short-Term Complications Admission Rate (PQI 1) | Agency for Healthcare Research and Quality |
| **0273** | Perforated Appendix Admission Rate (PQI 2) | Agency for Healthcare Research and Quality |
| **0274** | Diabetes Long-Term Complications Admission Rate (PQI 3) | Agency for Healthcare Research and Quality |
| **0275** | Chronic obstructive pulmonary disease (PQI 5) | Agency for Healthcare Research and Quality |
| **0277** | Congestive Heart Failure Admission Rate (PQI 8) | Agency for Healthcare Research and Quality |
| **0278** | Low birth weight (PQI 9) | Agency for Healthcare Research and Quality |
| **0279** | Bacterial pneumonia (PQI 11) | Agency for Healthcare Research and Quality |
| **0281** | Urinary Tract Infection Admission Rate (PQI 12) | Agency for Healthcare Research and Quality |
| **0283** | Adult asthma (PQI 15) | Agency for Healthcare Research and Quality |
| **0285** | Rate of Lower-Extremity Amputation Among Patients With Diabetes (PQI 16) | Agency for Healthcare Research and Quality |
| **0638** | Uncontrolled Diabetes Admission Rate (PQI 14) | Agency for Healthcare Research and Quality |
| **0717** | Number of School Days Children Miss Due to Illness | Maternal and Child Health Bureau |
| **0720** | Children Who Live in Communities Perceived as Safe | Maternal and Child Health Bureau |
| **0721** | Children Who Attend Schools Perceived as Safe | Maternal and Child Health Bureau |
| **0723** | Children Who Have Inadequate Insurance Coverage For Optimal Health | Maternal Health and Child Bureau |
| **0727** | Gastroenteritis Admission Rate (pediatric) | Agency for Healthcare Research and Quality |
| **0728** | Asthma Admission Rate (pediatric) | Agency for Healthcare Research and Quality |
| **1330** | Children With a Usual Source for Care When Sick | Maternal and Child Health Bureau, Health Resources & Services Administration |
| **1332** | Children Who Receive Preventive Medical Visits | Maternal and Child Health Bureau, Health Resources & Services Administration |

| NQF Number | Title | Steward |
|---|---|---|
| **1333** | Children Who Receive Family-Centered Care | Maternal and Child Health Bureau, Health Resources & Services Administration |
| **1334** | Children Who Received Preventive Dental Care | Maternal and Child Health Bureau, Health Resources & Services Administration |
| **1335** | Children Who Have Dental Decay or Cavities | Maternal and Child Health Bureau, Health Resources & Services Administration |
| **1337** | Children With Inconsistent Health Insurance Coverage in the Past 12 Months | Maternal and Child Health Bureau, Health Resources & Services Administration |
| **1340** | Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care | Maternal and Child Health Bureau, Health Resources & Services Administration |
| **1346** | Children Who Are Exposed To Secondhand Smoke Inside Home | Maternal and Child Health Bureau, Health Resources & Services Administration |
| **1348** | Children Age 6-17 Years who Engage in Weekly Physical Activity | Maternal and Child Health Bureau, Health Resources & Services Administration |
| **1349** | Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI) | Maternal and Child Health Bureau, Health Resources & Services Administration |
| **1351** | Proportion of infants covered by Newborn Bloodspot Screening (NBS) | HRSA |
| **1354** | Hearing screening prior to hospital discharge (EHDI-1a) | Centers for Disease Control and Prevention \| Early Hearing Detection and Intervention (EHDI) |
| **1357** | Outpatient hearing screening of infants who did not complete screening before hospital discharge (EHDI-1c) | Centers for Disease Control and Prevention \| Early Hearing Detection and Intervention (EHDI), |
| **1382** | Percentage of low birth weight births | Division of Vital Statistics \| National Center for Health Statistics, CDC |
| **1385** | Developmental screening using a parent completed screening tool (Parent report, Children 0-5) | Maternal and Child Health Bureau, Health Resources & Services Administration |
| **1419** | Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers | University of Minnesota |
| **0011** | Promoting Healthy Development Survey (PHDS) | Oregon Health & Science University |

## Appendix D: Related and Competing Measures

**Comparison of NQF #0023, NQF #0421, and NQF #1690**

| | 0023: BMI in adults > 18 years of age | 0421: Preventive Care and Screening: BMI Screening and Follow-up | 1690: Adult BMI Assessment |
|---|---|---|---|
| **Steward** | City of NY Department of Health and Hygiene | Centers for Medicare and Medicaid Services | City of NY Department of Health and Hygiene |
| **Description** | Percentage of adults 18 years old or older with valid BMI documentation in the past 24 months. | 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 | The percentage of adults 18–74 years of age who had body mass index (BMI) documented. |
| **Type** | Process | Process | Process |
| **Data Source** | Electronic Clinical Data, Electronic Health Records | Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Medical Records Medicare Part B Claims Data is provided for testing purposes. This measure is also EHR retooled. Per NQF permission, the feasibility, reliability & validity testing results will be provided with the 2013 annual measure update. | Electronic Clinical Data, Electronic Health Records |
| **Level** | Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Population : County or City, Population : Regional | Clinician : Group/Practice, Clinician : Individual, Population : County or City, Population : National, Population : Regional, Population : State | Clinician : Group/Practice, Clinician : Individual, Health Plan, Population : National |
| **Setting** | Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic | Ambulatory Care : Clinician Office/Clinic, Ambulatory Care : Outpatient Rehabilitation, Behavioral Health/Psychiatric : Outpatient, Home Health, Other Dental & Domiciliary Care | Ambulatory Care : Clinician Office/Clinic |

| | 0023: BMI in adults > 18 years of age | 0421: Preventive Care and Screening: BMI Screening and Follow-up | 1690: Adult BMI Assessment |
|---|---|---|---|
| **Numerator Statement** | Adults 18 years old or greater with BMI documented in the past 24 months. | ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION. | Adults 18 years old or greater with BMI documented in the past 24 months. |
| **Numerator Details** | Time Window: past 24 months<br>Height and weight need to be recorded in as structured format so that a resulting valid BMI can be calculated | Time Window: This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. BMI measured and documented in the medical record may be reported if done in the provider's office/facility or if BMI calculation within the past six months is documented in outside medical records obtained by the provider. The documentation of a follow up plan should be based on the most recent calculated BMI.<br>For the purposes of calculating performance, the Numerator (A) is defined by providers reporting the clinical quality action was performed. For this measure, performing the clinical quality action is numerator HCPCS G8420, G8417 & G8418. All discussed coding detail is listed in ´2a1.7. Denominator Details" section below. | Time Window: The measurement year (12 month calendar year) or the year prior.<br>ADMINISTRATIVE SPECIFICATION:<br>BMI during the measurement year or the year prior to the measurement year as identified using the following codes:<br>HCPCS: G8417-G8420; ICD-9-CM Diagnosis:V85.0-V85.5<br>MEDICAL RECORD SPECIFICATION:<br>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.<br>For patients younger than 19 years on the date of service, documentation of BMI percentile also meets criteria:<br>• BMI percentile documented as a value (e.g., 85th percentile)<br>• BMI percentile plotted on an age-growth chart. |

| | 0023: BMI in adults > 18 years of age | 0421: Preventive Care and Screening: BMI Screening and Follow-up | 1690: Adult BMI Assessment |
|---|---|---|---|
| **Denominator Statement** | Total number of patients 18 years old or greater seen in the measurement period. | ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.<br>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. | Adults 18-74 years of age who had an outpatient visit |
| **Denominator Details** | Time Window: 24 months<br>Age documented in the patients demographic screen during check-in and a documented valid E&M code for the visit | | Time Window: The measurement year (12 month calendar year) or the year prior.<br><br>CPT<br>99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456<br>HCPCS<br>G0344, G0402<br>ICD-9-CM Diagnosis<br>V70.0, V70.3, V70.5, V70.6, V70.8, V70.9<br>UB Revenue<br>051x, 0520-0523, 0526-0529, 0982, 0983 |

| | 0023: BMI in adults > 18 years of age | 0421: Preventive Care and Screening: BMI Screening and Follow-up | 1690: Adult BMI Assessment |
|---|---|---|---|
| **Exclusions** | Providers can exclude patients based on medical reason, patient reason, or systemic reason. | ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.<br>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:<br>There is documentation in the medical record that the patient is over or under weight and is being managed by another provider<br>If the patient has a terminal illness-life expectancy is 6 months or less<br>If the patient is pregnant<br>If the patient refuses BMI measurement<br>If there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate<br>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. | Optional Exclusion: Adults who have a diagnosis of pregnancy during the measurement year or the year prior |
| **Exclusion Details** | Provider can suppress a patient's inclusion in the denominator by a special button next to the measure and by documenting the reason and timeframe for the suppression. The number of these exclusions are captured and are queryable in our quality measure reports. | Denominator Exclusions (B) are identified with the following provider reported HCPCS numerator clinical quality code:<br>BMI not Calculated, Patient not Eligible/not Appropriate<br>G8422 Patient not eligible for BMI calculation<br>DENOMINATOR EXCLUSION CALCULATION:<br>Denominator Exclusions (B)(G8422)/Total Denominator Population (TDP)(G8420, G8417, G8418, G8421, G8419 & G8422) | ICD-9-CM Diagnosis for pregnancy<br>630-679, V22, V23, V28 |
| **Risk Adjustment** | No risk adjustment or risk stratification | No risk adjustment or risk stratification | No risk adjustment or risk stratification |
| **Stratification** | Measures can be stratified by reporting facility | No stratification. All eligible patients are subject to the same numerator criteria. | |

| | 0023: BMI in adults > 18 years of age | 0421: Preventive Care and Screening: BMI Screening and Follow-up | 1690: Adult BMI Assessment |
|---|---|---|---|
| **Type Score** | Continuous variable better quality = score within a defined interval | Rate/proportion better quality = higher score | Rate/proportion better quality = higher score |
| **Algorithm** | BMI = lb * 703 / in2 | THIS SECTION PROVIDES DEFINITIONS & FORMULAS FOR THE NUMERATOR (A), TOTAL DENOMINATOR POPULATION (TDP), DENOMINATOR EXCLUSIONS (B) CALCUATION & PERFORMANCE DENOMINATOR (PD) CALCULATION.<br>NUMERATOR (A): HCPCS Clinical Quality Codes G8420, G8417 & G8418<br><br>TOTAL DENOMINATOR POPULATION (TDP): Patient aged 18 years and older on the date of the encounter of the 12-month reporting period, with denominator defined encounter codes & Medicare Part B Claims reported HCPCS Clinical Quality Codes G8420, G8417, G8418, G8422, G8421 & G8419<br>DENOMINATOR EXCLUSION CALCULATION:<br>Denominator Exclusion (B): # of patients with valid exclusions<br># G8422 / # TDP<br>PERFORMANCE DENOMINATOR CALCULATION:<br>Performance Denominator (B): Patients meeting criteria for performance denominator calculation<br># A / (# TDP - # B) URL n/a Please see attached "NQF 0421 Endorsement - Quality Insights of Pennsylvania 050112" document on page 46. Attachment error noted. | 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.<br>Step 2. Search administrative systems and pharmacy data to identify numerator events for all members in the eligible population.<br>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.<br>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.<br>Step 5. Calculate the rate. |

| | 0023: BMI in adults > 18 years of age | 0421: Preventive Care and Screening: BMI Screening and Follow-up | 1690: Adult BMI Assessment |
|---|---|---|---|
| **Submission items** | | | |

i Nash DB, Reifsnyder J, Fabius R, Pracilio VP. Population Health: Creating a Culture of Wellness, Sudbury, Massachusetts: Jones & Bartlett Learning; 2011.

ii Kindig DA, Asada Y, Booske B, A population health framework for setting national and state health goals, JAMA, 2008;299(17):2081-2083.

iiiInput to the Secretary of Health and Human Services on Priorities for the National Quality Strategy.