NATIONAL QUALITY FORUM

1030 15TH STREET, NW, SUITE 800
WASHINGTON, DC 20005
202 783-1300 MAIN 783-3434 FAX

POPULATION HEALTH (PHASE I) -

PREVENTION ENDORSEMENT MAINTENANCE:

TECHNICAL REPORT

JUNE 2012

TABLE OF CONTENTS

POPULATION HEALTH (PHASE I) -
PREVENTION ENDORSEMENT MAINTENANCE: TECHNICAL REPORT

INTRODUCTION

Improving population health is an integral component of the Department of Health and Human Services' (HHS) National Strategy for Quality Improvement (the National Quality Strategy). 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. The NQF-convened National Priorities Partnership (NPP) selected Population Health as one of six national priorities, with a particular focus on ensuring receipt of preventive services, healthy behaviors, and community-based assessments of health. The National Prevention Strategy released in June 2011 specifically included a strategic direction focused on clinical and community preventive services. In this first phase of the Population Health project NQF seeks to maintain and expand previous efforts in clinical prevention and immunization measures for the healthcare sector. Endorsement maintenance provides the opportunity to harmonize specifications and to ensure that endorsed measures represent the best-in-class. The second phase of the Population Health project will focus on clinical healthy lifestyle behavior and population-level measures.

MEASURE EVALUATION

The Population Health Steering Committee evaluated two new measures and 18 measures undergoing maintenance review against NQF's evaluation criteria (January 2011). The Steering Committee included expertise in clinical preventive services, immunizations, health determinants, public health and population health. To facilitate the evaluation of Phase I measures, Committee members were divided into two workgroups that reviewed the clinical preventive services and immunization measures. The workgroups focused on evaluation of the sub-criteria and criteria, with input on overall suitability for endorsement from the broader Steering Committee on September 13-14, 2011. The Committee also provided important population-level context for the measures. The Committee's discussion and workgroup ratings of the criteria are summarized in the evaluation tables beginning on page 6.

Table 1. Clinical Preventive Services and Immunization Measure Maintenance Summary

	MAINTENANCE	NEW	TOTAL
Measures under consideration	**23**	**2**	**25**
Withdrawn from consideration	**5**		**5**
Recommended	**17**	**2**	**19**
Maintenance deferred	**1**		**1**
Not recommended	**0**	**0**	**0**

Overarching Issues

During the Steering Committee's discussion of the measures, several overarching issues emerged that were factored into the Committee's ratings and recommendations for multiple measures and are not repeated in detail with each individual measure.

Universal measure/Multiple related measures

The Steering Committee expressed a desire for universal measures for influenza and pneumococcal immunization in light of the multiple measures presented and the need for harmonization. The Committee suggested a universal measure that incorporates all of the various populations included in the influenza immunization measures. The Committee acknowledged that the differences in data sources are a limiting factor at the present time but should be a goal for the near future.

Harmonization

The Steering Committee reviewed the recommendations for harmonization of immunization measures from NQF's 2008 report *National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations*, and supported the basic construct of the standard specifications. The standard specifications were updated to align with current Advisory Committee on Immunization Practices (ACIP) guidelines as needed. Several comments requested clarification of the timing included in the specifications for influenza vaccination. The measures which align to the standard specifications collect data from October 1 – March 31. If a patient has been vaccinated in the current season prior to October 1, it is captured as a "vaccination received".

The Committee recommended that the vaccination measures align with the standard specifications whenever possible, but also asked that further analysis be done to assess the need for additional harmonization. The Steering Committee noted that many of the measures are sourced from various divisions within the federal government and further harmonization across care settings should be achievable over time. The Centers for Medicare and Medicaid services (CMS) responded that they are fully committed to the initiative but reiterated the inherent challenges of achieving harmonization or developing universal immunization measures across varied settings and data sources. Furthermore, CMS cautioned that harmonization must be a collective effort that involves other measure developers. They explained that the specifications for the immunization measures submitted to this project are setting-specific and therefore require different data sources, exclusions, and accountability.

Relationship to Population Health

The Committee discussed the relationship of the prevention measures to population health. They agreed that aggregation of the separate measures from different settings, such as for flu vaccination, would not be a valid indicator of population health because the current measures require interaction with the healthcare system. The personal health care system and the public health care system examine these issues differently. For example, the Committee emphasized that immunization data would optimally come from a public health registry that included the full population, rather than only those who seek care, and include information on the morbidity and mortality associated with the preventable condition. There was a recognition that clinical preventive services measures could complement more community-based or public health measures.

Disparities
Very few of the maintenance measures presented to the Steering Committee contained data related to disparities. The Committee requested additional disparities information and measure stratification for disparities from measure developers. NQF staff advised the Committee of an on-going Healthcare Disparities and Cultural Competency Consensus Standards project and a commissioned paper to provide background for disparities measurement.

MEASURES RECOMMENDED

Immunizations

- 0431 Influenza vaccination among healthcare personnel
- 0522 Influenza immunization- home health
- 0226 Influenza immunization in the ESRD population
- 0039 Flu shots for ages 50 and over
- 0041 Influenza immunization
- 1659 Influenza immunization (hospital)
- 0043 Pneumonia vaccination for older adults
- 0617 Pneumococcal vaccination
- 1653 Pneumococcal immunization (hospital)
- 0525 Pneumococcal vaccine ever received (home health)
- 0038 Childhood immunizations

Screening

- 0034 Colorectal cancer screening
- 0033 Chlamydia screening
- 0032 Cervical cancer screening
- 0579 Annual cervical cancer screening for high-risk patients
- 0037 Osteoporosis testing in older women
- 0046 Osteoporosis screening or therapy for women aged 65 years and older
- 0614 Steroid use- osteoporosis screening
- 0629 Male smokers or family history of AAA – screening for AAA

Measure deferred

- 0031 Breast cancer screening

MEASURE EVALUATION TABLES

0431 Influenza Vaccination Coverage Among Healthcare Personnel (Maintenance measure)

Measure Submission Form

Description: Percentage of healthcare personnel (HCP) who receive the influenza vaccination.

Numerator Statement: HCP in the denominator population who during the time from October 1 (or when the vaccine became available) through March 31 of the following year:

(a) received an influenza vaccination administered at the healthcare facility, or reported in writing (paper or electronic) or provided documentation that influenza vaccination was received elsewhere; or

(b) were determined to have a medical contraindication/condition of severe allergic reaction to eggs or to other component(s) of the vaccine, or history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination; or

(c) declined influenza vaccination; or

(d) persons with unknown vaccination status or who do not otherwise meet any of the definitions of the above-mentioned numerator categories.

Numerators are to be calculated separately for each of the above groups.

Denominator Statement: Number of HCP who are working in the healthcare facility for at least 30 working days between October 1 and March 31 of the following year, regardless of clinical responsibility or patient contact.

Denominators are to be calculated separately for:

(a) Employees: all persons who receive a direct paycheck from the reporting facility (i.e., on the facility's payroll).

(b) Licensed independent practitioners: include physicians (MD, DO), advanced practice nurses, and physician assistants only who are affiliated with the reporting facility who do not receive a direct paycheck from the reporting facility.

(c) Adult students/trainees and volunteers: include all adult students/trainees and volunteers who do not receive a direct paycheck from the reporting facility.

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: None

Measure Type: Process

Data Source: Electronic Clinical Data, Management Data, Paper Records, Patient Reported Data/Survey

Level of Analysis: Facility

Measure Steward: Centers for Disease Control and Prevention

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 8, No- 0

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

Rationale:

The Committee agreed on high impact and considerable performance gap.

- Agreement of high consistency and quantity of evidence, and moderate quality of evidence supporting vaccination as specified by measure.

Scientific Acceptability of Measure Properties: Yes- 8, No- 0

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- General Committee agreement on moderate reliability and validity.
- Some concern noted regarding accuracy of self-reports – the developer replied that "self-report of influenza vaccination has been studied among adults, and it's been found to be a highly sensitive and specific measure;" however, documentation, rather than self-report, was most common in the pilot test.
- Some concern was raised regarding lack of risk adjustment.
- Committee would like to see stratification for disparities of both the personnel and the patient population included in the specifications.

Usability: High-5, Moderate-3, Low-0, Insufficient-0

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

Rationale:

- Not currently reported, but a CMS rule is pending.
- Required by The Joint Commission for hospitals.
- Actionable information.

Feasibility: High-1, Moderate-7, Low-0, Insufficient-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:

- Measure relies on employee self-reports.
- Concern regarding likelihood of credible, near-term path to electronic capture.

Steering Committee: RECOMMEND FOR ENDORSEMENT

Does the measure meet criteria for endorsement? Yes-15, No-0

Rationale: The measure is evidence-based and consistent with healthcare personnel influenza immunization standard measure specifications. The measure could be improved by including all potential personnel contacts within a facility, including contractors, and evaluating immunization rates of various groups. Disparities assessments should evaluate both the employees and the patient populations.

Recommendation:

The Committee strongly recommends that this measure be reported with stratification for disparities in both the workforce and patient populations. At the next maintenance review, the developers should present data addressing disparities in both populations.

If Applicable, Conditions/Questions for Measure Developer:

- Consider including outsourced and contract workers (i.e. food and custodial services) to the denominator population. The measure as currently specified does not capture these personnel.
- Please explain the purpose of numerator category "d" (persons with unknown vaccination status or who do not otherwise meet any of the definitions of the above-mentioned numerator categories) under 2a1.1.
    - Is this the group that fails the measure?
- Steering Committee recommends that the data be stratified to reveal any potential disparities and equity concerns within workforce and patient populations

Developer response:

- We elected not to include contract workers in the denominator of the measure because the results of our pilot testing suggested that data on these personnel would be incomplete and therefore of limited validity. For example, we found that:

    - 27% of pilot facilities reported their ability to determine the vaccination status of other non-employees as a major barrier to using the measure
    - 28% of pilot facilities do not currently collect data on other non-employees vaccinated at the facility, and 45% do not collect data on other non-employees vaccinated outside the facility.
    - 23% of facilities felt that the denominator data they reported for other non-employees was "not at all" accurate.
    - When asked about specific personnel groups, 27% of facilities reported they could not or did not track vaccination among contracted custodial workers, and 45% reported having no such workers at the facility.

    In our assessment of face validity, our Delphi panel of experts did not achieve consensus on inclusion of contracted custodial workers or contracted cafeteria workers. In each case, although 5 panel members believed that inclusion of these groups could produce valid data, 3 panel members felt that including these groups would not produce valid data. We elected to include in the revised measure only those non-employee groups that produced strong consensus of face validity among our panel, as these results were corroborated by our quantitative survey data.

    Finally, we found that "other non-employees" (which included contract workers as well as students, volunteers, construction workers, medical vendors, etc.) comprised only 2% of the reported workforce at all pilot facilities (ranging up to 10% of HCP in pilot hospitals). Therefore, the exclusion of this category of HCP results in a more valid measure without substantially reducing the comprehensiveness of the measure. However, if NQF feels that it is important to include these personnel in spite of the potential for producing data of lower validity, these groups could be included with the third denominator category, as follows: "Adult students/trainees, volunteers, and contracted food service and custodial workers".
- This group [numerator category "d"] would be considered to be unvaccinated when vaccination rates are computed. The purpose of numerator category "d" is twofold. First, given the reported difficulties in tracking the numerator status of non-employee healthcare personnel, we felt that asking facilities to report the number of HCP with unknown status would result in greater transparency and would serve to alert reporting facilities if the reported numerator categories do not sum to the reported denominator number. Secondly, highlighting personnel with unknown vaccination status as a separate numerator category provides facilities with actionable data to assess improvements in ability to track HCP influenza vaccination, declination, and contraindication rates from year to year. However, if NQF feels strongly that this category is inconsistent with the harmonized NQF influenza vaccination measure, we are happy to delete it and use only numerator categories a, b, and c, as described in Section 2a.1.1.

CDC appreciates the recommendations of the Steering Committee and will provide stratified data that may be used to monitor potential disparities or inequities in vaccination during the next endorsement maintenance cycle. Because the address and zip codes of the reporting facilities will be available, we should be able to report influenza vaccination rates of healthcare personnel in facilities located in disadvantaged areas compared to those in more affluent areas.

Public & Member Comment
Comments included:

- The current measure specifications do not align with TJC's standard for influenza immunization for healthcare personnel. TJC includes contract personnel in their standard and points out that contract personnel include registered nurses and others with direct patient contact.

Developer response: The measure that was piloted during feasibility testing included contract personnel; however, many facilities participating in the pilot were unable to collect the necessary data for contract personnel. Furthermore, the majority of personnel identified by their pilot facilities were employees and licensed practitioners, citing that among hospitals, a median of only 10% of personnel were identified as "other non-employees", a group that included – but was not limited to – contracted workers. The CDC also stated that the pilot data indicated that 75% of facilities (including 99% of hospitals) offer influenza vaccination to contract personnel in their vaccination programs, and therefore, measurement of vaccination among a subset of facility personnel may accurately capture vaccination coverage among all personnel (as all have similar opportunities for vaccination). Finally, inclusion of contract workers in the measure holds the potential for public reporting of data of questionable accuracy. CMS plans to include the measure in its Hospital Inpatient Quality Reporting Program for reporting by acute care hospitals beginning in January 2013, and measure data will be publicly reported on www.hospitalcompare.hhs.gov. For these reason, they are reluctant to include contract personnel in the measure specifications during this endorsement maintenance cycle.

Committee response: Following lengthy discussion the Steering Committee failed to reach consensus on whether to require revision of the measure to include contract employees at this time. The Committee continues to support the measure of influenza immunization of health care workers.

Developer response (updated): In response to the discussion and subsequent re-vote on the measure, the CDC proposed a phased approach to include contract personnel that will not be completed until the next NQF maintenance review. The maintenance review would provide an opportunity for comments on measure specifications relating to contract workers. Additionally, this will allow time for facilities to develop their data and reporting systems to accurately capture denominator and numerator data for contract personnel. The CDC has initiated preliminary conversations with The Joint Commission to identify specific categories of contract workers that should be included in the first revision of the measure specifications.

- Suggests the inclusion of an "unknown" category to monitor those personnel who are not captured in other numerator categories in order to achieve 100% participation among healthcare personnel affiliated with the facility. The unknown category is one that should be made available to facilities to ensure that all personnel included in the denominator can also be accounted for the numerator, but personnel should not be assigned to this category until the end of an influenza season when all efforts to identify their vaccination status have failed.

Committee response: The Steering Committee is in favor of this suggested approach by the CDC.

0522 Influenza Immunization Received for Current Flu Season (Home Health) (Maintenance measure)

Measure Submission Form

Description: Percentage of home health episodes of care during which patients received influenza immunization for the current flu season.

Numerator Statement: Number of home health episodes of care during which the patient a) received vaccination from the HHA or b) had received vaccination from HHA during earlier episode of care, or c) was determined to have received vaccination from another provider.

NOTE: Number of home health episodes of care during which the patient was offered and refused vaccine; AND Number of home health episodes of care during which the patient was determined to have medical contraindication(s) are computed separately and reported to agencies but are not reported publicly.

Denominator Statement: Number of home health episodes of care ending during the reporting period, other than those covered by generic or measure-specific exclusions.

Adjustment/Stratification: No risk adjustment or risk stratification

Denominator Exclusions: Episodes which do not include any days during the flu season (October 1 - March 31). Episodes which ended with patient death. Episodes in which the patient does not meet the CDC guidelines for influenza vaccine

Measure Type: Process

Data Source: Electronic Clinical Data

Level of Analysis: Facility

Measure Steward: Centers for Medicare & Medicaid Services

Importance to Measure and Report: Yes- 8, No- 0

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

Rationale:

- General Committee agreement of high impact and significant performance gap (national average 66%).
- Disparities data are presented for race, age and gender.
- Agreement of high quantity of evidence, and moderate quality and consistency of evidence supporting immunization as specified by measure.
- Discussed Lancet article that concluded "…It's ineffective in the prevention of influenza, influenza-like illness and pneumonia. It does not reduce hospitalization rates and death, but does reduce hospitalization for influenza and pneumonia, and reduce all cause mortality."

Scientific Acceptability of Measure Properties: Yes- 8, No- 0

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- The Committee questioned the use of "episodes" rather than patients.
- Moderate reliability and validity ratings.
- Some concern regarding lack of risk adjustment/stratification.

Usability:High-2, Moderate-6, Low-0, Insufficient-0

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

Rationale:

- Minimal evidence provided for usability, particularly usefulness for public reporting.

Feasibility: <u>High-2, Moderate-6, Low-0, Insufficient-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)

Rationale:

- Some concern regarding patient self-reports.

Steering Committee: <u>RECOMMEND FOR ENDORSEMENT</u>

Does the measure meet criteria for endorsement? <u>Yes-15, No-0</u>

Rationale: The Committee noted the high impact in this vulnerable patient population and the considerable performance gap of 66%. The Committee questioned the use of episodes rather than patients and noted that harmonization was important and information on disparities is not included.

If Applicable, Conditions/Questions for Measure Developer:

- Setting-specific wording (i.e. home health) should be included in the measure title to distinguish between similar immunization measures.
- Explain rationale for using "episodes" rather than "patients".
- How are second home health episodes or hospitalizations in the flu season assessed?
    - Are these counted twice? Only once, for the first episode/hospitalization?

Developer response:

- We have added the phrase "Home Health" to the end of the measure name to distinguish this measure from other influenza vaccine measures– the new name will be *Influenza immunization received for current flu season (Home Health)* and this change is reflected on the forms.
- A home health quality episode is defined as the period of time between the patient's start of care (SOC) or resumption of care (ROC) and that patient's transfer (TRN) to an inpatient facility or discharge (DC) from care. Quality episodes can vary in length and are distinct from the 60-day fixed length period used for home health prospective payment. The definition of quality episode is consistent across all home health measures calculated using OASIS assessment data and is conceptually similar to a hospitalization or a nursing home stay. This measure establishes how well the HHA implements a process – checking the patient's vaccination status – and this process is applicable for each home health episode. Even if the HHA served the patient previously, each episode represents an opportunity to confirm the patient has received appropriate vaccinations and is thus the conceptually sensible unit of measurement. While our denominator definition differs from that of other influenza measures, it is consistent with other home health measures and is conceptually appropriate.---We appreciate the committee's recommendation. However, it is not possible to harmonize this measure's denominator with the immunization consensus standards while also remaining consistent with other home health measures calculated from OASIS data.
- Each home health quality episode that overlaps influenza season, including second episodes for the same patient, is included in the measure. For reference, 82% of patients who received care during flu season in 2010 had only one episode, while 18% had two or more episodes. Thus the 18% of patients with two or more episodes during flu season would be counted more than once.

Public & Member Comment
Comments included:

- Comments suggested that the measure should assess patients rather than episodes.

Developer response: Plan to pursue modification of the measure for patients rather than episodes using the method of the nursing home immunization measures. Revision and testing are anticipated by the next annual review in 2013.
Committee response: The Committee recommends the measure as is for now and looks forward to the anticipated revisions in 2013.

0226 Influenza Immunization in the ESRD Population (Facility Level) (Maintenance measure)

Measure Submission Form

Description: Percentage of end stage renal disease (ESRD) patients aged 6 months and older receiving hemodialysis or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31 who either received, were offered and declined, or were determined to have a medical contraindication to the influenza vaccine.

Numerator Statement: Number of patients from the denominator who:

1. received an influenza vaccination* -documented by the provider or reported receipt from another provider by the patient (computed and reported separately); OR
2. were assessed and offered an influenza vaccination but declined (computed and reported separately); OR
3. were assessed and determined to have a medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, and/or bone marrow transplant within the past 6 months (<6 months prior to encounters between October 1 and March 31).

*Only inactivated vaccine should be used in the ESRD population.

Denominator Statement: All ESRD patients aged 6 months and older receiving hemodialysis and/or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31 (computed and reported separately).

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: None.

Measure Type: Process

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

Level of Analysis: Facility

Measure Steward: Kidney Care Quality Alliance

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 8, No- 0

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

Rationale:

- High impact and moderate performance gap cited by Committee (testing results: vaccinated + declined + contraindications = 97.1%; range = 78 -100%).
- Specified population falls within ACIP recommendations for high risk populations.
- A relatively small, but high-risk population. This measure is at the facility-level, rather than the patient level, evaluating the performance of dialysis facilities.
- High ratings on quantity, quality, and consistency of evidence.

Scientific Acceptability of Measure Properties: Yes- 8, No- 0

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- High reliability and moderate validity ratings.
- Need for stratification to assess disparities.

Usability: High-3, Moderate-4, Low-0, Insufficient-1

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

Rationale:

- High rating for usability particularly for facilities.
- Harmonization is important.

Feasibility: High-3, Moderate-4, Low-0, Insufficient-1

(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 collected manually from "facility records".
- CMS plans implementation using CROWNWeb (web –based data collection).

Steering Committee: RECOMMEND FOR ENDORSEMENT

Does the measure meet criteria for endorsement? Yes-11, No-1

Rationale: The Committee noted the focus of this facility-level measure on a high-risk population with significant risk of infection complications, strong supporting evidence of benefit of immunization and alignment with the standard specifications. The Committee recommends that risk stratification and disparities assessment be included in the next update.

If Applicable, Conditions/Questions for Measure Developer: Further consideration of harmonization.

Public & Member Comment

Comments included: Recommendation that a start date be incorporated into the measurement period to avoid variation in measurement and interpretation. Revise measurement period to July 1 through March 31 and eliminate "or when the vaccine becomes available".

Developer response: The measure is harmonized with the NQF Influenza Immunization Standard Measure Specifications published in its 2008 National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations report, in which the denominator is defined as "the number of persons in a facility, agency, or practice with an encounter between October 1 and March 31." According to the guidelines, earlier vaccinations also are allowed to avoid missing an opportunity to vaccinate. The standard specifications take both of these recommendations into account." The phrase "or when the vaccine becomes available" is included so as to avoid penalizing providers in those instances in which patients are immunized prior to October to avoid missing an opportunity to vaccinate. Such patients are included in the measure and will be reflected in providers' scores.

Committee response: The Committee agreed with the developer's response and did not change their recommendation.

0039 Flu Shots for Adults Ages 50 and Over (Maintenance measure)

Measure Submission Form

Description: This measure represents the percentage of adults aged 50 and over who received an influenza vaccine within the measurement period within the respective age-stratified CAHPS surveys. This measure is only reported by age group stratification. The terms FSA and FSO, defined below, will be used to identify any differences between the two age stratifications.

FSA - A rolling average represents the percentage of members 50–64 years of age who received an influenza vaccination between September 1 of the measurement year and the date on which the CAHPS 4.0H adult survey was completed.

FSO - The percentage of Medicare members 65 years of age and older who received an influenza vaccination between September 1 of the measurement year and the date on which the Medicare CAHPS survey was completed.

Numerator Statement: The number of patients in the denominator who responded, "Yes" to the question "Have you had a flu shot since September 1, YYYY?

*YYYY = the measurement year (2010 for the survey fielded in 2011).

Denominator Statement: FSO (65+) – The number of members who responded "Yes" or "No" to the question, "Have you had a flu shot since September 1, YYYY?"

FSA (50-64) – The number of members with a Flu Shots for Adults Ages 50-64 Eligibility Flag of "Eligible" who responded "Yes" or "No" to the question "Have you had a flu shot since September 1, YYYY?"

*YYYY = the measurement year (2010 for the survey fielded in 2011).

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: Does not meet age criteria

Measure Type: Process

Data Source: Paper Records

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Health Plan, Integrated Delivery System

Measure Steward: National Committee for Quality Assurance

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 8, No- 0

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

Rationale:

- Moderate to high evidence ratings -- new ACIP recommendations include everyone over age 6 months.
- This measure does not capture the entire population recommended for immunization.

Scientific Acceptability of Measure Properties: Yes- 8, No- 0

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- Moderate reliability and validity ratings, no threats to validity identified.
- The measure should be stratified for assessment of disparities.
- Survey question administered through CAHPS surveys.
- Survey method captures patients who get vaccines outside the healthcare system.
- Survey measure – does "no" include contraindications or refusals? How often do these occur?

Usability: High-5, Moderate-3, Low-0, Insufficient-0

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

Rationale:

- Moderate to high usability rating.
- Longstanding reporting of performance data by NCQA on public website.
- Measure used by HEDIS and NCQA's Health Plan Accreditation program and others.

Feasibility: High-5, Moderate-2, Low-1, Insufficient-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 collected through CAHPS surveys, not routine clinical care.
- Measure has precise specifications for reporting.

Steering Committee: RECOMMEND FOR ENDORSEMENT

Does the measure meet criteria for endorsement? Yes-11, No-1

Rationale: The measure has been in widespread use as a survey question included in CAHPS surveys. The measure does not capture all recommended populations. Publicly reported data identify a considerable performance gap. Disparities should be assessed in order to provide targeted solutions in at risk communities

If Applicable, Conditions/Questions for Measure Developer:

- Are NCQA's childhood and adolescent immunization measures specified for influenza for these populations [both are NQF-endorsed measures]?
- Explain how patients that do not answer the question ("have you had a flu shot since September 1, YYYY?") are assessed.
    - Are these patients excluded from the measure or are they included in the denominator and counted against the measure?
    - Provide data on how often patients do not answer the question.

Developer response:

- Yes – influenza vaccination is included in NCQA childhood and adolescent immunization measures
- Per CAHPS methodology, the denominator is people who respond "Yes" or "No" to Q44. If responses are missing, nonsensical (e.g. multiple choices are marked) or "Don't Know", then they are excluded from the measure. As data below indicate, the total percentages of those excluded due to missing answers, multiple marks (commercial plans only), and the answer "Don't Know" were 8.3% for commercial plans and 7.1% for Medicare plans. It is important to note that this methodology is part of the CAHPS survey methodology and not specific to just this particular measure.

HEDIS 2011 Adult Commercial Flu Shot Responses			
Flu Shot Response Options	**Plans**	**Sum of Responses Across Plans**	**Percent**
Q44. Yes	410	80518	43.9
Q44. No	410	87616	47.7
Q44. Don't Know	410	1351	0.7
Q44. Multiple Mark	410	55	0.0
Q44. Missing	410	14019	7.6
Totals		183559	100.0

HEDIS 2010 Medicare Flu Shot Responses			
Flu Shot Response Options	**Plans**	**Sum of Responses Across Plans**	**Percent**
Had a flu shot since Sept. 1, 2009-Yes (1)	403	131064	60.6
Had a flu shot since Sept. 1, 2009-No (2)	403	70062	32.4
Had a flu shot since Sept. 1, 2009-Don't Know (3)	389	2284	1.1
Had a flu shot since Sept. 1, 2009-Missing (.)	403	13020	6.0
Totals		216430	100

Steering Committee Workgroup (following developer's response and/or modifications): RECOMMEND FOR ENDORSEMENT

Does the measure meet criteria for endorsement? FINAL Yes-7; No-1

Public & Member Comment

Comments included:

- Unclear whether FSA and FSO Medicare members ages 50-64 as well as members >65 years who received the influenza vaccination prior to September 1 are counted in the outcome measure. Recommendation to expand the denominator to include patients who received their influenza vaccination prior to September 1.
- Concern that the measure does not capture all recommended populations and the public reported data identify a considerable gap between actual and perceived/recalled performance. Revisit in one year.

Developer response:

- The FSO measure (65+) is collected for the Medicare Advantage population and the FSA measure (50-64) is collected for the commercial population. NCQA and its advisory panels are interested in moving the starting date from September 1 to a date more closely in line with when the vaccine becomes available to providers. NCQA will look at making this change at the same time we look at expanding the age range of the measure for commercial members.
- NCQA and its advisory panels are currently working to align measure with the ACIP guidelines. In 2012 we will be testing a revised measure which will look to expand the lower age limit to 18 and re-specify the survey questions to account for the different vaccinations recommended for the different age groups. NCQA is unclear about the "gap between actual and perceived/recalled performance" to which the commenter is referring. This measure has been cognitively tested across populations and is considered valid and reliable by several measurement advisory panels. Additionally, the self-report measure allows for measurement of vaccination which may have occurred outside of the clinical setting (e.g. at work or in the community).

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

0041 Influenza Immunization (Maintenance measure)

[SPECIFICATIONS REVISED AFTER STEERING COMMITTEE MEETING] **Measure Submission Form**

Description: Percentage of patients aged 6 months and older seen for a visit between October 1 and the end of February who received an influenza immunization OR patient reported previous receipt of an influenza immunization

Numerator Statement: Patients who received an influenza immunization OR who reported previous receipt* of influenza immunization

*Previous receipt can include: receipt of influenza immunization from another provider OR receipt of influenza immunization from same provider during a visit prior to October 1

Denominator Statement: All patients aged 6 months and older seen for a visit between October 1 and the end of February

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reason)

Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reason)

Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reason)

Measure Type: Process

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

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

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 10, No- 0

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

Rationale:

- Impact on outcomes not clear for entire population as specified in measure (rather than high-risk populations which are well-documented) though it is consistent with ACIP guidelines.
- Evidence presented addresses high risk groups rather than the entire population.

Scientific Acceptability of Measure Properties: Yes- 10, No- 0

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- Concerns regarding lack of stratification for disparities assessment

Usability: High-3, Moderate-6, Low-1, Insufficient-0

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

Rationale:

- Not harmonized/aligned with NQF's standard specifications – exclusions are removed from the denominator
- Overlaps with other existing measures

Feasibility: <u>High-2, Moderate-7, Low-1, Insufficient-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)

Rationale:

- Concerns about data collection strategy - dependence self-reported data

Steering Committee (Initial Recommendation): <u>NOT RECOMMEND FOR ENDORSEMENT</u>

Does the measure meet criteria for endorsement? <u>Preliminary Yes-4, No-8</u>

Rationale:

- Committee noted that the measure as currently specified is not aligned with NQF's standard specifications for influenza vaccinations:
    - The measure includes the "percentage of patients aged 6 months and older seen for a visit between October 1 and the end of February who received an influenza immunization OR patient reported previous receipt of an influenza immunization", while the standardized time window is October 1 through March 31.
    - Measure has denominator exclusions that are not consistent with standard specifications or harmonized with other flu vaccination measures. The Committee reiterated that the denominator should include every patient.

If Applicable, Conditions/Questions for Measure Developer:

- Developer asked to address concerns noted above

Developer response:

- To promote greater consistency with the guidelines from the Advisory Committee on Immunization Practices (ACIP) and direct alignment with the standard measure specifications recommended by NQF for influenza immunizations, the AMA PCPI Preventive Care Work Group agrees to modify the measure accordingly. The denominator and measure description now reads as follows:
  Denominator: All patients aged 6 months and older seen for a visit between October 1 and March 31
  Measure Description: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

- Clarification Regarding Measure Exceptions
  We understand there may have been some confusion as to how exceptions are applied in PCPI measures. According to PCPI methodology, the denominator represents the group of patients for inclusion in a specific performance measure based on defined criteria (in this case, all patients aged 6 months and older seen for a visit between October 1 and March 31). We offer the following additions and clarifications regarding the PCPI measure exception methodology as requested in sections 2a1.9 and 2a1.20 of the submission forms.

  2a1.9 Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)***:**
  The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure 0041, exceptions may include medical reason(s) (eg, patient allergy) patient reason(s) (eg, patient declined) or system reason(s) for the patient not receiving influenza immunization (eg, vaccine not available, other system reasons). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the *specific* reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows:

For Electronic Health Record specifications - See attached for PCPI eSpecification *(updated eSpecification with calculation algorithm included with this response)*
For Claims/Administrative specifications,
Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reason)
Append modifier to CPT Category II code: 4274F-1P
Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reason)
Append modifier to CPT Category II code: 4274F-2P
Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reason)
Append modifier to CPT Category II code: 4274F-3P

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

To calculate performance rates:

1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).
2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). *Note: in some cases the initial patient population and denominator are identical.*
3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator
4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) (eg, patient allergy), patient reason(s) (eg, patient declined), or system reason(s) (eg, vaccine not available)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation.
--Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

Steering Committee Workgroup (following developer's response and/or modifications): <u>RECOMMEND FOR ENDORSEMENT</u>

Does the measure meet criteria for endorsement? <u>FINAL Yes-9; No-1</u>

The Committee appreciated the adjustment made to the inclusion dates to further harmonization. This measure addresses the full population recommended by ACIP including children. Though not completely aligned with standard specifications, the developer has modified the measure to meet the standard vaccination parameters. The remaining issue of exclusion reporting and PCPI's use of exceptions is broader than this specific measure/project. Disparities must be assessed in order to provide targeted solutions in at risk communities.

Public & Member Comment

Comments Included:

- Add tag onto the title to indicate intended populations to which this applies, i.e. "patients > 6 months of age"
- Concerns about capturing patients who were immunized prior to October 1
- lack of alignment with standard specifications and the other influenza immunization measures (exclusions are removed from the denominator rather than included in numerator categories)

Developer response:

- The title currently reflects the broad nature of the measure without specifying the age range for whom the measure applies. If greater specificity is strongly recommended, we could consider the modification with our expert work group.
- Confirmed that influenza immunizations assessed and administered prior to October 1 of the current influenza season are captured in the numerator population.
- The measure was designed to be congruent with the cited guidance from the CDC ACIP.

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

1659 Influenza Immunization (New measure)

Measure Submission Form

Description: Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.

Numerator Statement: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated.

Denominator Statement: Inpatients age 6 months and older discharged during the months on October, November, December, January, February or March.

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: Excluded patients consist of the following; Patients who expire prior to hospital discharge and patients with an organ transplant during the current hospitalization. See the 2a1.9 for ICD-9 and ICD-10 tables for transplants.

Measure Type: Process

Data Source: Administrative claims, Paper Records

Level of Analysis: Facility, Population: National, Population: Regional, Population: State

Measure Steward: Centers for Medicare and Medicaid Services

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 8, No- 0

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

Rationale:

- Current gap for overall pneumonia patients (93%) is small, but is likely to be larger for the general hospital population.
- Large national sample of hospitalized patients with pneumonia demonstrates a gap among ethnic minorities
- High quantity, quality, and consistency ratings of evidence; Cochrane review of 51 studies

Scientific Acceptability of Measure Properties: Yes- 8, No- 0

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- High reliability agreement for all data elements

Usability: High-5, Moderate-3, Low-0, Insufficient-0

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

Rationale:

- High -Moderate usability rating

Feasibility: High-2, Moderate-6, Low-0, Insufficient-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:

- Minimal rationale for using non-electronic sources and no specification of credible, near-term path to electronic capture

Steering Committee: <u>RECOMMEND FOR ENDORSEMENT</u>
Does the measure meet criteria for endorsement? <u>Preliminary Yes-12, No-1</u>
Rationale:
The Committee notes the high impact of this broad measure that captures all hospitalized patients and the performance gap. The Committee notes some concern with continued use of paper records as the data source and need for path to electronic capture.

If Applicable, Conditions/Questions for Measure Developer:

- Steering Committee's recommendation – setting-specific wording (ie. hospital-based setting) should be included in the measure title to distinguish between similar immunization measures.
- How are second hospitalizations in the flu season assessed? Are these counted twice? Only once, for the first hospitalization?
- Please explain why transplantation is an exclusion and not a medical contraindication in the numerator.
- Are the stratification details intended to be the numerator categories specified in the standard specifications? Will they be computed and reported separately as indicated in the standard specifications?
- Further consideration of harmonization.

Developer response:

- For the inpatient measures, we look at inpatient hospitalizations, not individual patients per se. If there are multiple inpatient hospitalizations, we look to see that quality care is provided each time. For a case in which a patient had an inpatient hospitalization multiple times during a single flu season, the status would be assessed at each discharge and if indicated, they should receive the vaccine. A case would pass the measure if any of the following were documented,
    1) Influenza vaccine was given during this hospitalization
    2) Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization
    3) Documentation of patient's or caregiver's refusal of influenza vaccine
    4) There was documentation of an allergy/sensitivity to influenza vaccine, anaphylactic latex allergy or anaphylactic allergy to eggs OR is not likely to be effective because of bone marrow transplant within the past 6 months OR history of Guillian-Barre Syndrome within 6 weeks after a previous influenza vaccination

  Currently there is no way to "link" hospitalizations for the individual measures required as a part of the IQR program. However, as noted above, if a patient is vaccinated during the first of a series of admissions during flu season, the hospital simply needs to document prior vaccination for that flu season and the case will pass the measure for each admission.

- Using transplantation as an exclusion allows the case to be excluded using ICD-9/ICD-10 codes. These cases can be excluded prior to the abstractor abstracting the case, thus decreasing abstractor burden and abstractor mistakes.

Transplantation is not a contraindication to vaccination (there are no reported complications of vaccination of a transplant patients). However, the effectiveness (antibody response) of the influenza or pneumococcal vaccine may be blunted in a patient who is undergoing organ transplant due to immunosuppression used for these patients. In consultation with our expert panel which included strong representation from the Centers for Disease Control and Prevention, we made the decision to exclude from the denominator those patients who are undergoing organ transplantation during the hospitalization. Ideally these patients are vaccinated prior to their hospitalization for transplant before they undergo intense immunosuppression. We routinely encourage transplant centers in our educational efforts to vaccinate patients at the earliest point when they are identified as candidates for transplant.

- In 2008, CMS along with partners including The Joint Commission came to agreement on harmonized vaccination measures across settings (hospitals, nursing homes, home health agencies) that were incorporated into the NQF's National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations (December 2008). The performance measures were aligned with recommendations from the Advisory Committee on Immunization Practices. At that time, the consensus standards created four numerator categories for influenza and pneumococcal vaccination:
  - Vaccinated during admission
  - Vaccine received prior to admission
  - Patient refusal
  - Patient contraindication

  The data collection tools and analytic algorithms allow for stratification and reporting of the each of the numerator categories, and allow for the calculation and reporting of a single overall measure rate.
  CMS is still working out how they will be able to report the stratification on Hospital Compare.

- Harmonization issues:

Latex allergy - This exclusion was implemented because one of the vaccine companies uses latex in the rubber stoppers of their pre-filled syringes. So this was a packaging issue. When we discussed this issue with our TEP, they recommended we add the latex anaphylaxis exclusion. How are the other measures handling this issue? In the days of Value-Based Purchasing, CMS must address issues such as this.

Steering Committee Workgroup (following developer's response and/or modifications): <u>RECOMMEND FOR ENDORSEMENT</u>
Does the measure meet criteria for endorsement? <u>FINAL Yes-8; No-0</u>

Public & Member Comment:
Comments Included:

- If this measure applies to "hospitals" why does the denominator population include patients in nursing homes and skilled nursing facilities?
- Have these measures been tested?
- Lack of electronic data sources or near term path to achieving electronic data.
- APIC guidelines indication that "people who are moderately or severely ill should usually wait until they recover before getting flu vaccine." Many hospitalized patients may be moderately or severely ill and should not be included in this measure.

Developer response:

- Measure applies to inpatient hospital populations and the only way it would include another type of patient other than hospital inpatients is if another facility used the same provider number. Some hospitals may contain psych units or rehab units and bill under the same facility number and those patients would be included.
- Submission form includes assessments of reliability and validity on the subset of patients who had pneumonia. Results would not differ substantially with the expanded population.
- At present, not able to accept data from EHRs. However, when the functionality becomes available, this measure will likely be specified for this data format.
- Vaccine status should be assessed at discharge. Patients well enough to be discharged, should be well enough to receive the vaccine.

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

0043 Pneumonia vaccination status for older adults (Maintenance measure)

Measure Submission Form

Description: Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination

Numerator Statement: The number of patients in the denominator who responded "Yes" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in the person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."

Denominator Statement: The number of members who responded "Yes" or "No" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: Does not meet age criteria

Measure Type: Process

Data Source: Administrative claims, Healthcare Provider Survey, Paper Records, Patient Reported Data/Survey

Level of Analysis: Clinician: Group/Practice, Clinician: Individual, Clinician : Team, Facility, Health Plan, Integrated Delivery System, Population : County or City

Measure Steward: National Committee for Quality Assurance

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 8, No- 0

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

Rationale:

- PPV 23 is recommended, but some of the evidence cited includes valence 7.
- Measure does not include high-risk, under 65 years populations.
- ACIP recommendation for immunization.

Scientific Acceptability of Measure Properties: Yes- 8, No- 0

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- Survey question administered in the Hospital Outcomes Survey (HOS) for Medicare Advantage patients – only captures a small portion of the over 65 years population.
- Questions regarding implications of patients who do not answer/missing data

Usability: High-5, Moderate-3, Low-0, Insufficient-0

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

Rationale:

- High-moderate usability – limited population captured by the measure.

Feasibility: High-5, Moderate-3, Low-0, Insufficient-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:

- High-moderate feasibility - challenges of survey based measure.

Steering Committee: RECOMMEND FOR ENDORSEMENT
Does the measure meet criteria for endorsement? Preliminary Yes-11, No-0
Rationale:
The Committee supported the importance and evidence base for pneumonia vaccination but noted the limitations of a survey measure and that this measure only addresses patient over age 65.

If Applicable, Conditions/Questions for Measure Developer:

- Please explain how patients that do not answer the following question are assessed: "Have you ever had a pneumonia shot? (This shot is usually given only once or twice in the person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine.")
    - Are these patients excluded from the measure or are they included in the denominator and counted against the measure?
    - Please provide data on how often patients do not answer the question.

Developer response:

Per CAHPS methodology, the denominator is people who respond "Yes" or "No" to Q87. If responses are missing or "Don't Know", then they are excluded from the measure. As data below indicate, the total percentage of those excluded was 13.6% for Medicare plans, due missing answers and the response "Don't Know". It is important to note that this methodology is part of the CAHPS survey methodology and not specific to just this particular measure.

HEDIS 2010 MEDICARE PNEUMONIA SHOT RESPONSES			
Variable	**Plans**	**Sum of Responses Across Plans**	**Percent**
Q87. Yes	403	125273	57.9
Q87. No	403	61793	28.6
Q87. Don't Know	403	16136	7.5
Q87. Missing	403	13228	6.1
Totals		216430	100

Steering Committee Workgroup (following developer's response and/or modifications): RECOMMEND FOR ENDORSEMENT
Does the measure meet criteria for endorsement? FINAL Yes-8; No-0

Public & Member Comment
Comments Included: Recommend revising the title to Pneumococcal "Immunization" Status for Older Adults. Term "immunization" is consistent with those for influenza and it is more precise term to describe this vaccine.

Developer response: NCQA will be making a name change to Pneumococcal Vaccination Status for Older Adults for HEDIS 2013, as well as the name for the measure NQF 0043.

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

0617 High Risk for Pneumococcal Disease - Pneumococcal Vaccination (Maintenance measure)

[SPECIFICATIONS REVISED AFTER STEERING COMMITTEE MEETING] **Measure Submission Form**

Description: The percentage of patients age 5-64 with a high risk condition, or age 65 years and older who:

1. Received a pneumococcal vaccine (reported separately)
2. Had a contraindication to pneumococcal vaccine(reported separately)

Numerator Statement: Two separate numerators:

1. Patients who receive a pneumococcal vaccine
2. Patients who have a contraindication to pneumococcal vaccine

Denominator Statement: Patients who are between 5-64 years with a high risk condition (e.g., diabetes, heart failure, COPD, end-stage kidney disease, asplenia, malignancy, solid organ transplant, on immunosuppressive medications,) or patients age 65 years and older.

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: General exclusions:

- Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months;
- Patients who have been in a skilled nursing facility in the last 3 months

Measure Type: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry, Other

Level of Analysis: Clinician: Group/Practice, Clinician: Individual, Clinician: Team, Facility, Health Plan, Integrated Delivery System, Population : Community, Population : County or City, Population : National, Population : Regional, Population : State

Measure Steward: Active Health Management

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: **Yes- 8, No- 0**

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

Rationale:

- Significant gap --vaccination rate among high-risk adults ages 19-54 is only 17%; for over 65 years rate is 61%.
- Disparities are documented.

Scientific Acceptability of Measure Properties: **Yes- 8, No- 0**

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- Measure not risk adjusted/stratified.
- The measure uses administrative data for vaccine administration; Active Health's implementation also uses information from Personal Health Records (PHRs) and nurse interviews about whether vaccine was received.
- Considerable documentation of code sets for numerator and denominator.
- Test data and client data compliance rates agree.

Usability: High-5, Moderate-1, Low-2, Insufficient-0

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

Rationale:

- No information on the use for quality improvement provided.
- Initial submission not harmonized with standard specifications – developer indicated they are willing to harmonize.

Feasibility: High-5, Moderate-2, Low-1, Insufficient-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:

- Measure uses a combination of data sources to mitigate risk of inaccuracies or errors.
- High burden on data management.

Steering Committee: RECOMMEND FOR ENDORSEMENT PENDING UPDATES

Does the measure meet criteria for endorsement? Preliminary Yes-4, No-9

Rationale:

The measure as currently specified is not aligned with standard specifications for pneumococcal vaccinations. The Committee is willing to consider revised, harmonized specifications if they can be done quickly.

If Applicable, Conditions/Questions for Measure Developer:

- Harmonization with NQF's standard specifications and ACIP 2011 guidelines.
- The numerator and denominator exclusionary criteria are inappropriately applied. The Committee reiterated that the denominator should always include every patient who should receive the vaccine.

Developer response:

- Our measure has been modified to align with the NQF standard specification (described below).
- We have included the literature on the controversial evidence for pneumococcal vaccine as per the committee.
  The ACIP recommends in the "Prevention of Pneumococcal Disease Among Infants and Children — Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine" report that immunocompetent children 2 years and older with a chronic illness (chronic heart disease, chronic lung disease, diabetes, cerebrospinal fluid leaks or cochlear implant) should receive 1 dose of PPSV23 at age 2 or older and more than 8 weeks after their last dose of PCV13. One supplemental dose of PSV13 is recommended for children ages 24 through 71 months with an underlying medical condition who have received all age appropriate doses of PSV7. In our measure, we look for people ages 5-64 with a chronic condition and look for a pneumococcal 23 vaccine anytime in the past since the recommendation is 24 months through 71 months.

  Reference: CDC. Prevention of Pneumococcal Disease Among Infants and Children — Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine. Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR (2010). 59; No. RR-11

- We have revised our denominator and are no longer excluding those who have a contraindication to pneumococcal vaccine. We have created 2 numerators – one looking at those who have received the vaccine and a second numerator looking at those who have a contraindication to the vaccine. These will be reported separately. We are unable to capture in a codified manner whether the pneumococcal vaccine specifically was refused by the patient, since there is only a general procedure code that a patient refused a vaccine.

Steering Committee Workgroup (following developer's response and/or modifications): RECOMMEND FOR ENDORSEMENT

Does the measure meet criteria for endorsement? FINAL Yes-7; No-1

The Committee appreciates the developer's quick response in providing harmonized specifications.

Public & Member Comment
Comments included:

- The measure needs to be harmonized with NQF Standard specifications and ACIP recommendations.
- Concerned that limiting the measure specifications to PPV23 alone will inappropriately discourage providers from using alternative forms of pneumococcal vaccination, when CMS has recognized that other vaccines can be utilized to fulfill the measure. NQF withhold recommending the measure until it is revised.

Developer response:

- The original measure specifications were revised to harmonize with NQF standard specifications.
- At the time of the NQF submission deadline, the ACIP guidelines recommended use of PPV23 for people under 64 with high risk conditions and those over the age of 65. Although PCV13 is recommended for children at high risk, PPV23 is still recommended for this same population 8 weeks after their last dose of PCV 13. Therefore it is accurate to state that while PCV13 is necessary for children, it does not provide sufficient coverage for those children at high risk without PPV23. While the FDA has recently (12/2011) approved PCV13 for use in adults over the age of 50, we are awaiting the CDC ACIP updates for 2012 to determine the adequacy of this vaccine for high risk populations. In the meantime, we stand by our current measure specifications as they reflect the guidelines at the time of our submission. Lastly should the CDC guidelines be updated after endorsement is achieved for this measure, we will update this measure during the annual update process to reflect any changes that the CDC recommends.

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

1653 Pneumococcal Immunization (PPV 23) (New measure)

Measure Submission Form

Description: Inpatients age 65 years and older and 6-64 years of age who have a high risk condition who are screened for 23-valent Pneumococcal Polysaccharide Vaccine (PPV23)status and vaccinated prior to discharge if indicated.

Numerator Statement: Inpatient discharges who were screened for PPV23 status and received PPV23 prior to discharge if indicated.

Denominator Statement: Inpatient discharges 65 years of age and older and 6-64 years of age who have a high risk condition.

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: Excluded patients consist of the following; Patients who expire prior to hospital discharge, patients with an organ transplant during the current hospitalization and pregnant women. See attachments of the ICD-9 and ICD-10 tables for transplants and pregnancy.

Measure Type: Process

Data Source: Administrative claims, Paper Records

Level of Analysis: Facility, Population : National, Population : Regional, Population : State

Measure Steward: Centers for Medicare and Medicaid Services

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 8, No- 0

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

Rationale:

- Very high rates (98%) in the pneumonia population – developer has no data on the current performance in the general inpatient population.

Scientific Acceptability of Measure Properties: Yes- 8, No- 0

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- The Committee requested more explanation of tracking disparities and use of public reporting to address disparities.

Usability: High-1, Moderate-7, Low-0, Insufficient-0

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

Rationale:

- Moderate usability rating.

Feasibility: High-1, Moderate-7, Low-0, Insufficient-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:

- Concern regarding feasibility of direct chart abstraction, no near-term path to electronic data.
- Concern with self-report – possible misinterpretation of measure would lead to repeat immunization to have documentation of vaccination rather than rely on self-report as counting for the measure

Steering Committee: DEFERRED at the meeting
Does the measure meet criteria for endorsement? No Vote
Rationale:
Developer not available to respond to questions and concerns at the meeting:

- What is the current performance? What is the opportunity for improvement?
- Numerator wording not clear that self-reports are counted and repeat vaccination should not occur.

If Applicable, Conditions/Questions for Measure Developer:

- What is known about current performance for all inpatients? What is the opportunity for improvement?
- Is it your intention that hospitals accept self-reports of past vaccination to count in the numerator? Please clarify.
- Is any auditing done to screen for possible over-vaccination?
- Harmonization with other flu vaccination measures.

Developer response:

- The only numbers we currently have for hospital in-patients were the numbers we provided for Pneumonia patients from the PN measures that were submitted with the measures. However, according to Medicare Fee for Service Claims Data, the national vaccination rate for the 2010-2011 influenza season was 50.26% and the national rate for pneumococcal vaccination for calendar year 2010 was 46.88%. Both of these show considerable room for improvement.
- Yes we do accept self-reported data. When speaking with members from ACIP and PIDS, both agreed that the national registers are not readily available to many hospitals and even if they are available are difficult to understand, especially in adolescence.
- Not at this time. The pneumococcal polysaccharide vaccine (PPSV23) is exceedingly safe. According to the CDC, The most common adverse reactions following either pneumococcal polysaccharide or conjugate vaccine are local reactions. For PPSV23, 30%–50% of vaccines report pain, swelling, or erythema at the site of injection. These reactions usually persist for less than 48 hours. Local reactions are reported more frequently following a second dose of PPSV23 vaccine than following the first dose. Moderate systemic reactions (such as fever and myalgia) are not common (fewer than 1% of vaccines), and more severe systemic adverse reactions are very rare. This was confirmed in a recent study of adults who received up to four doses of PPSV23 (Vaccine. 2011 Mar 9;29(12):2287-95.). Compared to first-time vaccines, re-vaccines reported more joint pain (p=0.004), fatigue (p=0.019), headache (p=0.014), swelling (p=0.006), and moderate limitation in arm movement (p=0.025). However, no serious reactions were reported and antibody responses were maintained in re-vaccines.

  We are aware that because the PPSV23 is recommended as a one-time vaccine in the elderly, some will forget that they have been previously vaccinated. This may result in re-vaccination of some patients. However, several years ago we evaluated the use of PPSV23 in physician office practices and found that re-vaccination was not uncommon in that setting also (patients forget their vaccination status whether in the hospital or in the office). Clearly the development of robust vaccine registries or use of health information technology/health information exchange will ultimately make long-term tracking of vaccination status feasible and should reduce the likelihood of revaccination.

  ACIP recommends vaccinating the patient if the vaccination status is unknown. They also recommend clear documentation of delivery of the vaccine so that the information is available to the next healthcare worker who cares for the patient.

Harmonization:

- For the inpatient measures, we look at inpatient hospitalizations, not individual patients per se. If there are multiple inpatient hospitalizations, we look to see that quality care is provided each time. For a case in which a patient had an inpatient hospitalization multiple times during a single flu season, the status would be assessed at each discharge and if indicated, they should receive the vaccine. The measures included in the Hospital Inpatient Reporting Program, formerly the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program looks at each discharge, not each patient. Currently there is no way to "link" hospitalizations for the individual measures required as a part of the IQR program.
- In 2008, CMS along with partners including The Joint Commission came to agreement on harmonized vaccination measures across settings (hospitals, nursing homes, home health agencies) that were incorporated into the NQF's National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations (December 2008). The performance measures were aligned with recommendations from the Advisory Committee on Immunization Practices. At that time, the consensus standards created four numerator categories for influenza and pneumococcal vaccination:
    - Vaccinated during admission
    - Vaccine received prior to admission
    - Patient refusal
    - Patient contraindication

  The data collection tools and analytic algorithms allow for stratification and reporting of the each of the numerator categories, and allow for the calculation and reporting of a single overall measure rate.

CMS is still working out how they will be able to report the stratification on Hospital Compare.

Steering Committee Workgroup (following developer's response and/or modifications): <u>RECOMMEND FOR ENDORSEMENT</u>

Steering Committee Workgroup: <u>FINAL Yes-8; No-0</u>

The developer responded to the questions and concerns.

Public & Member Comment
Comments included:

- If this measure applies to "hospitals" why does the denominator population include patients in nursing homes and skilled nursing facilities?
- Have these measures been tested?
- Lack of electronic data sources or near term path to achieving electronic data.
- Is there substantial overlap with the measure 0617 Pneumococcal immunization?
- What is the feasibility for patients to recall their status for the specific vaccine, 23-valent Pneumococcal Polysaccharide Vaccine (PPV23)?
- What is known about the use and safety about unnecessary re-vaccination in the case of faulty recall?

Developer response:

- Measure applies to inpatient hospital populations and the only way it would include another type of patient other than hospital inpatients is if another facility used the same provider number. Some hospitals may contain psych units or rehab units and bill under the same facility number and those patients would be included.
- Submission form includes assessments of reliability and validity on the subset of patients who had pneumonia. Results would not differ substantially with the expanded population.
- At present, not able to accept data from EHRs. However, when the functionality becomes available, this measure will likely be specified for this data format.
- Measure 0617 pneumococcal immunization assesses inpatient populations and measure 1653 assesses outpatient populations. Furthermore, both measures use different data sources. Data for measure 0617 is derived from claims and pharmacy records, while data for measure 1653 are chart abstracted.
- From our experience (1998-2011), many patients remembered their vaccination status and if they did not know their status, the recommendation was to vaccinate them per ACIP recommendations.
- The only side effect that occurs with any frequency in a revaccinated patient is local redness and swelling at the injection site. This is uncommon in the elderly, self-limited and of no significance other than showing that the patient still had circulating antibody. Revaccination with PPV is exceedingly safe.

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

0525 Pneumococcal Polysaccharide Vaccine (PPV) Ever Received (Home Health) (Maintenance measure)

Measure Submission Form

Description: Percentage of home health episodes of care during which patients were determined to have ever received Pneumococcal Polysaccharide Vaccine (PPV).
Numerator Statement: Number of home health episodes of care during which patients were determined to have ever received Pneumococcal Polysaccharide Vaccine (PPV).
Denominator Statement: Number of home health episodes of care ending during the reporting period, other than those covered by generic or measure-specific exclusions
Adjustment/Stratification: No risk adjustment or risk stratification
Exclusions: Episodes which ended in patient death. Episodes in which the patient does not meet the CDC age/condition guidelines for PPV vaccine.
Measure Type: Process
Data Source: Electronic Clinical Data
Level of Analysis: Facility
Measure Steward: Centers for Medicare and Medicaid Services, Office of Clinical Standards and Quality, Quality Measurement and Health Assessment Group

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 8, No- 0
(1a. Impact, 1b. Performance gap, 1c. Evidence)
Rationale:

- National performance rate = 60%.

Scientific Acceptability of Measure Properties: Yes- 8, No- 0
(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)
Rationale:

- No stratification for assessment of disparities included in the specification though data on disparities are presented.
- Needs additional clarification of specifications.
- Validation scores for the data elements are consistently over 90.

Usability: High-4, Moderate-3, Low-1, Insufficient-0
(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures)
Rationale:

- Harmonization question on episodes rather than patients.

Feasibility: High-1, Moderate-7, Low-0, Insufficient-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:

- Moderate feasibility.

Steering Committee: RECOMMEND FOR ENDORSEMENT
Does the measure meet criteria for endorsement? Preliminary Y-10, No-3
Rationale:

The Committee recommends that measure be publicly reported with stratification for disparities. The developer was referred to NQF's report from the Disparities and Cultural Competency Committee.

If Applicable, Conditions/Questions for Measure Developer:

- Setting-specific wording (i.e. home health) should be included in the measure title to distinguish between similar immunization measures
- Explanation needed for rationale for using "episodes" rather than "patients"
    - Committee recommendation: define home health episode so that it conforms to hospital and other settings standard – i.e. for one patient, not episode.

Developer response:

- We have added the phrase "Home Health" to the end of the measure name to distinguish this measure from other PPV measures – the new title will be *Pneumococcal polysaccharide vaccine (PPV) ever received (Home Health)* and this change is reflected on the forms.
- A home health quality episode is defined as the period of time between the patient's start of care (SOC) or resumption of care (ROC) and that patient's transfer (TRN) to an inpatient facility or discharge (DC) from care. Quality episodes can vary in length and are distinct from the 60-day fixed length period used for home health prospective payment. The definition of quality episode is consistent across all home health measures calculated using OASIS assessment data and is conceptually similar to a hospitalization or a nursing home stay. This measure establishes how well the HHA implements a process – checking the patient's vaccination status – and this process is applicable for each home health episode. Even if the HHA served the patient previously, each episode represents an opportunity to confirm the patient has received appropriate vaccinations and is thus the conceptually sensible unit of measurement. While our denominator definition differs from that of other immunization measures, it is consistent with other home health measures and is conceptually appropriate.
- We appreciate the committee's recommendation. However, it is not possible to harmonize this measure's denominator with the immunization consensus standards while also remaining consistent with other home health measures calculated from OASIS data.

Steering Committee Workgroup (following developer's response and/or modifications): <u>RECOMMEND FOR ENDORSEMENT</u>
Steering Committee Workgroup: <u>FINAL: Yes-8; No-0</u>

Public & Member Comment
Comments included: Comments suggested that the measure should assess patients rather than episodes

Developer response: Plan to pursue modification of the measure for patients rather than episodes using the method of the nursing home immunization measures. Revision and testing are anticipated by next annual review in 2013.

Committee response: The Committee recommends the measure a anticipated revisions.

0038 Childhood Immunization Status (Maintenance measure)

Measure Submission Form

Description: Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B(HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

Numerator Statement: Children who have evidence showing they received recommended vaccines during the measurement year.

Denominator Statement: Children who turn 2 years of age during the measurement year are eligible for inclusion.

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: Children who had a contraindication for a specific vaccine may be excluded from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. An organization that excludes contraindicated children may do so only if the administrative data do not indicate that the contraindicated immunization was rendered. The exclusion must have occurred by the second birthday. Organizations should look for exclusions as far back as possible in the member's history.

Individuals diagnosed with HIV. Look for evidence of HIV diagnosis as far back as possible in the member´s history through December 31 of the measurement year.

Individuals who have a diagnosis of pregnancy during the measurement year.

Measure Type: Process

Data Source: Administrative claims, Electronic Clinical Data : Registry, Paper Records

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Health Plan, Integrated Delivery System

Measure Steward: National Committee for Quality Assurance

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 8, No- 0

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

Rationale:

- High impact and important disparities that need addressing.
- Moderate performance gap due to high prevalence of certain vaccination rates.
- High quantity, quality, and consistency of evidence based on ACIP reviews.

Scientific Acceptability of Measure Properties: Yes- 8, No- 0

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- High reliability and moderate validity data.

Usability: High-7, Moderate-1, Low-0, Insufficient-0

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

Rationale:

- Existence of 10-12 separate measures complicates use in public reporting. The overall rate is most useful for public reporting.
- Documentation cites widespread use, but does not demonstrate usability of the information.

Feasibility: <u>High-5, Moderate-3, Low-0, Insufficient-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)

Rationale:

- Measure widely used, but documentation doesn't provide evidence of feasibility
- Data source is administrative and medical records.
- Some concerns with use of multiple data sources – are they comparable?
- Credible, near-term path to electronic capture.

Steering Committee: <u>RECOMMEND FOR ENDORSEMENT</u>

Does the measure meet criteria for endorsement? <u>Yes-13, No-1</u>

Rationale:

The Committee noted that this high-impact measure is a top priority in many national health goals. The measure is quite complex, with multiple, different rates. For public reporting and accountability, one or two overall or combination rates should be used. Due to the large number of vaccines included in the measure, adjustments may be necessary in times of vaccine shortages. Disparities must be assessed in order to provide targeted solutions in at risk communities.

Public & Member Comment

Comments included: Complex measure, with multiple, different rates. Recommend one or two overall or combination rates should be used for reporting and accountability.

Developer response: The measure contains multiple combination rates in order to allow for trending given the addition of new vaccines throughout the measure's lifetime. The combination rates allow health plans flexibility to assess their performance for specific vaccine combinations because for public reporting, health plans report both individual and combination antigen rates. The measure is in use in several federal programs, including meaningful use.

Committee response: The Committee debated the feasibility of designating a measure within the combination as primary, preferably the measure that includes the most antigens, and the rest as supplementary, but later concluded that this type of selection might introduce unintended consequences such as data variability. The Committee supported the developer's response and did not change their recommendation

SCREENING

0034 Colorectal Cancer Screening (Maintenance measure)

Measure Submission Form

Description: The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Numerator Statement: One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the four criteria below:

•fecal occult blood test (FOBT) during the measurement year

•flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year

•double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year.

•colonoscopy during the measurement year or the nine years prior to the measurement year.

Denominator Statement: Patients 51–75 years of age as of December 31 of the measurement year.

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: Patients with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the patient's history, through either administrative data or medical record review. Exclusionary evidence in the medical record must include a note indicating a diagnosis of colorectal cancer or total colectomy, which must have occurred by December 31 of the measurement year.

Measure Type: Process

Data Source: Administrative claims, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Paper Records

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

Measure Steward: National Committee for Quality Assurance

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 8, No- 0

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

Rationale:

- High impact and large performance gap – 2009 commercial plan data national rate = 60%.
- High quantity and moderate quality and consistency of evidence due to differing benefits/harms based on type of colorectal cancer screening.
- Measure aligns with USPSTF recommendations.

Scientific Acceptability of Measure Properties: Yes- 8, No- 0

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- High reliability and moderate validity ratings.

Usability: High-7, Moderate-0, Low-0, Insufficient-1

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

Rationale:

- High usability rating -Provides distinctive value among existing measures.
- Currently in use as a HEDIS measure.

Feasibility: <u>High-5, Moderate-2, Low-0, Insufficient-1</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)

Steering Committee: <u>RECOMMEND FOR ENDORSEMENT</u>

Does the measure meet criteria for endorsement? <u>Preliminary Yes-12, No-0</u>

Rationale:

The Committee supports this widely used HEDIS measure that demonstrates a considerable performance gap. The Committee recommends stratification for disparities.

If Applicable, Conditions/Questions for Measure Developer:

- Does a patient who gives a history of screening count in the measure?
    - How are the data captured?
- Need to review/revise the numerator specifications and information about virtual colonoscopy in the submission form ("Computed tomographic colonography (CTC) or virtual colonoscopy every four years or the four years prior to the measurement year").

Developer response:

- Evidence of a screening must follow the requirements delineated in the measure specifications. If using the medical record, documentation must include the following:
  One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following criteria:
    - FOBT during the measurement year
    - Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
    - Double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year.
    - Colonoscopy during the measurement year or the nine years prior to the measurement year

  Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. History of screening before the patient entered the health plan is acceptable as long as documentation meets the specifications above.
- Computed tomographic colonography (CTC) or virtual colonoscopy every four years or the four years prior to the measurement year" is not part of this measure specifications. The measure specifications have been updated on the NQF online submission forms.

Steering Committee Workgroup (following developer's response and/or modifications): <u>RECOMMEND FOR ENDORSEMENT</u>

Does the measure meet criteria for endorsement? <u>FINAL Yes-7; No-1</u>

0033 Chlamydia screening in women (Maintenance measure)

Measure Submission Form

Description: Assesses the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Numerator Statement: At least one chlamydia test during the measurement year as documented through administrative data.

Denominator Statement: Women 16–24 years.

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: Members who had a pregnancy test during the measurement year, followed within seven days (inclusive) by either a prescription for isotretinoin (Accutane) or an x-ray. This exclusion does not apply to members who qualify for the denominator based on services other than the pregnancy test alone. Refer to Table CHL-D and Table CHL-E to identify exclusions.

Measure Type: Process

Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy

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

Measure Steward: National Committee for Quality Assurance

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 8, No- 0

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

Rationale:

- High impact and performance gap due to large population at risk and underutilization of chlamydia screening – In 2009, 1.2 million Chlamydia cases were reported, an increase of 2.8%.
- Moderate to high evidence rating.

Scientific Acceptability of Measure Properties: Yes- 8, No- 0

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- Moderate reliability and validity due to the difficulty of accurately identifying sexually active women using claims data.
- NCQA compared medical record data with administrative data during development; there are issues with identifying sexually active women from the medical record also.

Usability: High-6, Moderate-2, Low-0, Insufficient-0

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

Rationale:

- High usability rating – HEDIS measure in widespread use.

Feasibility: High-4, Moderate-4, Low-0, Insufficient-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:

- Moderate feasibility rating.
- Data elements are consistent for mass-screening-need to clarify how the patient's "at risk" status is incorporated.
- Measure is impacted by ability to accurately identify sexually active women.

Steering Committee: RECOMMEND FOR ENDORSEMENT
Does the measure meet criteria for endorsement? Preliminary Yes-13, No-0
Rationale:
The Committee supports this widely used HEDIS measure, especially because there is a large at risk population and a considerable performance gap. Ongoing issues with identifying sexually active women from either administrative or chart data.

If Applicable, Conditions/Questions for Measure Developer:

- How are sexually active patients identified from administrative data?

Developer response:

- As documented in the specifications, there are two methods for identifying sexually active women using administrative data: pharmacy data and claim/encounter data. The organization must use both methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure.
  Pharmacy data. Members who were dispensed prescription contraceptives during the measurement year (the measure provides a list of prescriptions).
  Claim/encounter data. Members who had at least one encounter during the measurement year with any code in the table of CPT, HCPCS, ICD-9-CM Diagnosis, ICD-9-CM Procedure or UB Revenue codes provided in the measure

Steering Committee Workgroup (following developer's response and/or modifications): RECOMMEND FOR ENDORSEMENT
Does the measure meet criteria for endorsement? FINAL Yes-8; No-0

Public & Member Comment
Comments included: The current identification of sexually active women ages 16-24 by a proxy measure of the use of oral contraceptives may be inaccurate for women in this age group. Oral contraceptives are widely prescribed for acne for women of this age and this may not be a valid measure of identifying women who are sexually active.

Developer response: The method used for identifying the eligible population through claims is supported by field testing. In addition, the measure contains an exclusion for members who had a pregnancy test followed by a prescription for isotretinoin (Accutane).

Committee response: The Committee had no additional comments and did not wish to change their recommendation.

0032 Cervical Cancer Screening (Maintenance measure)

Measure Submission Form

Description: Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.

Numerator Statement: One or more Pap tests during the measurement year (one calendar year) or the two years prior to the measurement year.

Denominator Statement: Women 24-64 years of age.

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: Optional Exclusion: Women who had a hysterectomy with no residual cervix.

Measure Type: Process

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

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

Measure Steward: National Committee for Quality Assurance

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 9, No- 0

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

Rationale:

- High impact and performance gap rating due to prevalence of disease.
- Current national performance in plans: commercial =77%; Medicaid =66%.
- Racial and ethnic disparities persist – lower performance in Medicaid compared to commercial plans; plans have limited data on race and ethnicity and resort to geocoding to look at disparities.
- Measure aligns with USPSTF guideline based on comprehensive meta-analysis.

Scientific Acceptability of Measure Properties: Yes- 8, No- 1

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- High reliability and validity data.
- Clear, concise, reproducible exclusions.
- Recommend stratification for assessment of disparities.

Usability: High-7, Moderate-2, Low-0, Insufficient-0

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

Rationale:

- Use for quality improvement efforts with benchmarks.
- Widely used HEDIS measure.

Feasibility: High-8, Moderate-1, Low-0, Insufficient-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 available electronically, auditable.
- Potential areas of susceptibility identified including data entry, collection by non-health professionals.

Steering Committee: RECOMMEND FOR ENDORSEMENT
Does the measure meet criteria for endorsement? Preliminary Yes-12, No-0
Rationale:
This widely used HEDIS measure is based on strong evidence and USPSTF guidelines.
Disparities must be assessed in order to provide targeted solutions in at risk communities.

If Applicable, Conditions/Questions for Measure Developer:

- Needs stratification for assessing disparities
- Has NCQA considered developing an overuse measure for cervical cancer screening?
- The USPSTF in coordination with the American Cancer Society and American Society for Colposcopy and Cervical Pathology (ASCCP) announced draft recommendations on October 19, 2011 to update the recommendations from 2003.

Developer response:

- NCQA's HEDIS Health Plan measure set includes two measures that collect demographic data that will allow organizations to stratify HEDIS measures for disparities: Race/Ethnicity Diversity of Membership and Language Diversity of Membership. NCQA's work assessing innovations in culturally and linguistically appropriate services revealed that health plans are able to stratify existing HEDIS measures for race/ethnicity or language needs if they have these data on their members.
- NCQA may develop such a measure in the future
- The measure as submitted is aligned with the U.S. Preventive Services Task Force recommendations

Steering Committee Workgroup (following developer's response and/or modifications): RECOMMEND FOR ENDORSEMENT
Does the measure meet criteria for endorsement? FINAL Yes-9; No-0

Public & Member Comment
Comments included: The numerator statement of one calendar year or 2 years prior is confusing, the USPSTF recommends 3 year intervals and this should be explicitly stated in the measure.

Developer response: This numerator statement is supported by field testing and aligns with how numerator specifications are written for HEDIS health plan measures.

Committee response: The Committee had no additional comments and did not wish to change their recommendation.

0579 Annual Cervical Cancer Screening or Follow-up in High-Risk Women (Maintenance measure)

Measure Submission Form

Description: This measure identifies women age 12 to 65 diagnosed with cervical dysplasia (CIN 2), cervical carcinoma-in-situ, or HIV/AIDS prior to the measurement year, and who still have a cervix, who had a cervical CA screen during the measurement year.

Numerator Statement: Patients in the denominator who had a cervical CA screen during the measurement year

Denominator Statement: Women who are 12-65 years of age who have a diagnosis of cervical dysplasia (CIN 2), cervical carcinoma-in-situ, or HIV/AIDS diagnosed prior to the measurement year, and who still have a cervix (excludes women with a hysterectomy and no residual cervix).

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: No claims for cervical cancer screening exclusions, based on NCQA/HEDIS technical specifications: Women who had a hysterectomy with no residual cervix.

Measure Type: Process

Data Source: Administrative claims, Electronic Clinical Data : Pharmacy

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : Community, Population : County or City

Measure Steward: Resolution Health, Inc.

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 7, No- 1

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

Rationale:

- This is not the same as screening in the general population. ACOG's guidelines state, "Certain risk factors have been associated with CIN in observational studies… Women infected with HIV should have cervical cytology screening twice in the first year after diagnosis and annually thereafter. Women treated in the past for CIN2 or CIN3 or cancer remain at risk for persistent or recurrent disease and should continue to be screened annually."

Scientific Acceptability of Measure Properties: Yes- 7, No- 1

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- Measure specifications are consistent with ACOG recommendations.
- Moderate to high reliability and validity testing.

Usability: High-0, Moderate-8, Low-0, Insufficient-0

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

Rationale:

- Useful and usable by clinicians, particularly those involved in the care of large populations at risk, to assess professional performance and as a quality improvement tool.

Feasibility: High-1, Moderate-7, Low-0, Insufficient-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:

- Moderate feasibility rating.

Steering Committee: DEFERRED at the meeting
Does the measure meet criteria for endorsement? No Vote
Rationale: Committee raised questions about updates to guidelines and requested more information before proceeding.

NQF STAFF NOTE:

- The most recent ACOG guidelines were released in November 2009. ACOG guidelines state that:
  - " The interval between cervical cytology examinations may be extended to every 3 years for women at least aged 30 years who have had 3 consecutive negative cervical cytology screening test results and who have no history of CIN 2 or CIN 3, HIV infection, immune-compromised state, or DES exposure in utero (Level A)."
  - "Women previously treated for CIN 2, CIN 3, or cancer remain at risk for persistent or recurrent disease for at least 20 years after treatment and after initial post-treatment surveillance. This group should therefore continue to be screened annually for at least 20 years (Level B)".
- The USPSTF in coordination with the American Cancer Society and American Society for Colposcopy and Cervical Pathology (ASCCP) announced draft recommendations on October 19, 2011 to update the recommendations from 2003. These recommendations apply only to general screening and not to high-risk patients.

If Applicable, Conditions/Questions for Measure Developer:

- At the Steering Committee's in-person meeting, concern was raised about the measure's title. The Committee believed that the word screening was not an appropriate term for those with past history of cervical dysplasia – and that this should be considered surveillance rather than screening. The Committee suggested a change such as *Annual Pap smears for screening or follow-up in high-risk women*.
- The 2003 ACOG guidelines were cited in the submission form, however the most recent guidelines from ACOG are from 2009 –can you please address this discrepancy or update the information?

Developer response:

- We agree with changing the measure title, and propose the following: ***Annual cervical cancer screening or follow-up in high-risk women.*** Change was made to measure submission form.
- As for the guideline reference, we did review the 2009 guideline during our internal assessment of the measure, but apparently overlooked updating this citation in our submission form. Please see submission form for update.

Steering Committee Workgroup (following developer's response and/or modifications): RECOMMEND FOR ENDORSEMENT
Does the measure meet criteria for endorsement? FINAL Yes-7; No-1

Public & Member Comment
Comments included: Supports an annual review for guideline updates.

NQF response: The NQF measure maintenance process requires review of annual updates for any changes to evidence or specifications.

Committee response: The Committee had no additional comments and did not wish to change their recommendation.

0037 Osteoporosis testing in older women (Maintenance measure)

Measure Submission Form

Description: Percentage of female patients aged 65 and older who reported receiving a bone density test (BMD) to check for osteoporosis

Numerator Statement: The number of patients in the denominator who responded "yes" to the question, "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as "brittle bones"? This test may have been done to your back, hip, wrist, heel, or finger."

Denominator Statement: Women 65 and older as of December 31 of the measurement year who answered "yes" or "no" to the question, "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as "brittle bones"? This test may have been done to your back, hip, wrist, heel, or finger."

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: None

Measure Type: Process

Data Source: Patient Reported Data/Survey

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Health Plan, Integrated Delivery System, Population : National

Measure Steward: National Committee for Quality Assurance

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 8, No- 1

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

Rationale:

- *High impact and performance gap; national perf*ormance in plans (2009) = 69%.
- Only 30% of Medicare beneficiaries have not had at least one test.

Scientific Acceptability of Measure Properties: Yes- 8, No- 1

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- High reliability but only face validity data.
- Inquiries about comparability between survey and billing data. (See developer's response below.)

Usability: High-2, Moderate-6, Low-1, Insufficient-0

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

Rationale:

- Moderate usability rating.

Feasibility: High-1, Moderate-6, Low-2, Insufficient-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:

- Concern regarding feasibility and burden of survey for data collection.
- Concern regarding measures susceptibility to errors.

Steering Committee: DEFERRED at the meeting
Does the measure meet criteria for endorsement? No Vote
Rationale: The Committee identified a need to further compare osteoporosis measures 0037 and 0046 particularly whether a measure which relies on claims data is superior to measure that relies upon survey data

- Disparities must be assessed in order to provide targeted solutions in at risk communities

If Applicable, Conditions/Questions for Measure Developer:

- Please provide additional detailed information on the differences between this measure and measure #0046.
- Why are the data retrieved from survey rather than administrative data sources?

Developer response:

- Measure 0037 is conducted at the health plan level, and data collection is administered through the Medicare Health Outcomes Survey, a patient reported survey. The numerator focuses on females aged 65 and older who received a bone density test (BMD) for osteoporosis.

- Measure 0046 is conducted at the physician level, and data collection is administered through administrative claims. The numerator focuses female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months.

- Side-by-side comparison

Steering Committee Workgroup (following developer's response and/or modifications): RECOMMEND FOR ENDORSEMENT
Does the measure meet criteria for endorsement? FINAL Yes-7; No-3
Rationale:
Workgroup members noted that these two measures (see also 0046), which use different data sources (patient report and claims data) and are readily available, allow two different ways of accessing this information. Patient-reported data may be particularly helpful for women who have not been with a plan for a long time, and for whom claims data might dramatically under-represent screening rates. Some Workgroup members suggest that a claims-based measure (0046) is superior to survey-based measure.

Public & Member Comment
Comments included:

- Provide additional information on how patient refusal is captured.
- Concerns about recall bias

Developer response:

- Data are collected through patient self-report. The response categories do not include an exemption for patient refusal. NCQA has determined the prevalence of patient refusal is not large enough to have a significant impact on plan performance or result in significant differences across plans. All HEDIS measures are evaluated for potential exclusions by several advisory panels; exclusions deemed to cause a higher risk of confusion or measurement burden than added benefit of specificity are considered not appropriate.
- The most recent evidence on the use of bone mineral density tests for osteoporosis screening suggests an interval of up to 15 years between tests may be appropriate for individuals with no other risk factors. Given the long interval between tests, this information is not easily or reliably collected through claims or medical records. This may be especially true when an individual changes health plans. It is not currently possible to collect this information uniformly across plans using only administrative data. NCQA will continue to examine new and reliable methods to capture this information with the expanded uptake of electronic health records.

Committee response: The Committee had no additional comments and did not wish to change their recommendation.

0046: Osteoporosis Screening or Therapy for Women Aged 65 Years and Older (Maintenance measure)

Measure Submission Form

Description: Percentage of female patients aged 65 years and older who have a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months.

Numerator Statement: Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

Denominator Statement: All female patients aged 65 years and older

Adjustment/Stratification: No risk adjustment or risk stratification

Denominator Exclusions: Except patients for whom central DXA measurement was not ordered or performed and pharmacologic therapy was not prescribed by reason of appropriate denominator exception, including:

-Documentation of medical reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy

-Documentation of patient reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy

-Documentation of system reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy

Measure Type: Process

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

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

Measure Steward: National Committee for Quality Assurance

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 7, No- 2

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

Rationale:

- Osteoporosis is a high prevalence, high cost, significant morbidity condition.
- Low performance: 2008 PQRI data. Mean: 35.09%.
- This measure seems to be more specific in modality of screening (central DXA) compared to USPSTF and AACE recommendations.

Scientific Acceptability of Measure Properties: Yes- 7, No- 2

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- High degree of inter-rater reliability, including exclusions.
- Concern regarding false negatives due to specifications which look for DXA after age 60.
- Validity determined by expert panel.
- Measure not stratified for disparities.

Usability: High-5, Moderate-2, Low-2, Insufficient-0

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

Rationale:

- Measure used in CMS PQRI program.

Feasibility: <u>High-4, Moderate-4, Low-1, Insufficient-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)

Rationale:

- Several exceptions may require confirmation via paper chart or free text interpretation in EHRs.

Steering Committee: <u>DEFERRED at the meeting</u>

Workgroup Recommendation for Endorsement: <u>No Vote</u>

Rationale:

- Compare osteoporosis measures.
- Concern regarding congruency between USPSTF and AACE recommendation and measure.

If Applicable, Conditions/Questions for Measure Developer:

- Please provide additional detailed information on the differences between this measure and measure #0037.

Developer response:

- Measure 0046 is conducted at the physician level, and data collection is administered through administrative claims. The numerator focuses female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within12 months.
- Measure 0037 is conducted at the health plan level, and data collection is administered through the Medicare Health Outcomes Survey, a patient reported survey. The numerator focuses on females aged 65 and order who received a bone density test (BMD) for osteoporosis.

Steering Committee Workgroup (following developer's response and/or modifications): <u>RECOMMEND FOR ENDORSEMENT</u>

Does the measure meet criteria for endorsement? <u>FINAL Yes-7; No-3</u>

Rationale:

Workgroup members note that these two measures (see also 0037), which use different data sources (patient report and claims data) and are readily available, allow two different ways of accessing this information.

Public & Member Comment

Comments included:

- Concerned that several exceptions may require confirmation via paper chart or free text interpretation in EHRs - need to work with EHR vendors to improve reporting capabilities.
- The measure should allow FRAX scoring as an acceptable screening method for patients on chronic steroids.

Developer response:

- We are supportive of any efforts to better align EHR systems with performance measurement. NCQA is currently working on a set of e-Measures which will inform the continued evolution of EHR systems.
- We agree that patients on chronic steroids should receive continued monitoring for risk of osteoporosis rather than receive a single screening method. For this reason, these patients should fall under the medical exclusion category for this measure.

Committee response: The Committee had no additional comments and did not wish to change their recommendation.

0614 Steroid Use - Osteoporosis Screening (Maintenance measure)

Measure Submission Form

Description: The percentage of patients, 18 and older, who have been on chronic steroids for at least 180 days in the past 9 months and who had a bone density evaluation or osteoporosis treatment

Numerator Statement: Patients who have had a bone density evaluation or osteoporosis treatment.

Denominator Statement: Patients, 18 and older, who have been on chronic steroids for at least 180 days

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: Specific exclusions:

- Pregnancy

General exclusions:

- Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months
- Patients who have been in a skilled nursing facility in the last 3 months

Measure Type: Process

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

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Health Plan, Integrated Delivery System, Population : Community, Population : County or City, Population : National, Population : Regional, Population : State

Measure Steward: Active Health Management

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 7, No- 1

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

Rationale:

- A significant issue: "the incidence of new fractures after one year of glucocorticoid therapy can be as high as 17%, and observational studies suggest that fractures, which are often asymptomatic, occur in 30-50% of chronic glucocorticoid-treated patients."
- Small at-risk population in the test population of 2334 patients, performance =60%.
- Based on guideline from National Osteoporosis Foundation.

Scientific Acceptability of Measure Properties: Yes- 8, No- 0

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale: incomplete

- Moderate to high reliability and validity data.

Usability: High-1, Moderate-5, Low-2, Insufficient-0

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

Rationale:

- Relatively small at-risk population.

Feasibility: <u>High-2, Moderate-5, Low-0, Insufficient-1</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)

Rationale:

- Uses administrative data, though requires pharmacy and encounter data.

Steering Committee Workgroup: <u>DEFERRED at the meeting</u>

Does the measure meet criteria for endorsement? <u>No Vote</u>

Rationale:

- Measure deferred; to be discussed and evaluated with other osteoporosis measures.

Steering Committee Workgroup (following developer's response and/or modifications): <u>RECOMMEND FOR ENDORSEMENT</u>

Does the measure meet criteria for endorsement? <u>FINAL Yes-6; No-3</u>

Rationale:

The Workgroup notes that this measure is a reasonable addition to general screening to focus on high-risk populations; however, some express concern over the small at-risk population in this measure.

Public & Member Comment

Comments included:

- Concerned with the use of administrative data, though the measure requires pharmacy and encounter data
- Small at-risk population-value added proposition

Developer response:

- We include not only administrative data in our measure; we also use self reported data via our personal health record and data reported to nurses as part of our disease management program.
- This measure was initially tested on a smaller population. We expect that if run against a larger population, the denominator (i.e. the at- risk population) would also be larger and add to the value of this measure. Additionally, as data sources become more robust and enhancements are made in data ingestion processes, our expectation is that the performance gap of this measure will become more apparent.

Committee response: The Committee had no additional comments and did not wish to change their recommendation.

0629 Male Smokers or Family History of Abdominal Aortic Aneurysm (AAA) - Screening for AAA (Maintenance measure)

Measure Submission Form

Description: The percentage of men age 65-75 years with history of tobacco use or men age 60 yrs and older with a family history of abdominal aortic aneurysm who were screened for AAA

Numerator Statement: Men who have had AAA screening.

Denominator Statement: Men age 65-75 years with a history of tobacco use (current or ever) or Men age 60 and older with a family history of abdominal aortic aneurysm based on patient derived data or claims data

Time Window: Anytime in the past

Adjustment/Stratification: No risk adjustment or risk stratification

Exclusions: There are no specific exclusions to this measure.

General exclusions:

- Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months;
- Patients who have been in a skilled nursing facility in the last 3 months

Measure Type: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry, Patient Reported Data/Survey

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Health Plan, Integrated Delivery System, Population : Community, Population : County or City, Population : National, Population : Regional, Population : State

Measure Steward: Active Health Management

STEERING COMMITTEE EVALUATION

Importance to Measure and Report: Yes- 6, No- 2

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

Rationale:

- Moderate impact and performance gap: the developer reports "we identified 3563 patients who qualified for AAA screening, out of a total population of nearly 2.5 million lives. Out of those identified for this measure in the test data, only 1774, or 49.8% were screened with appropriate testing."
- Underutilization of screening in men aged 65-75.
- Moderate rating of evidence due to USPSTF meta-analysis which demonstrates effectiveness of one time AAA screening for smokers; concern regarding evidence for repeat testing.

Scientific Acceptability of Measure Properties: Yes- 7, No- 1

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)

Rationale:

- Clear data requirements and accessible data sources.
- Possible data limitations due to reliance on claims data for smoking cessation.

Usability: High-1, Moderate-7, Low-0, Insufficient-0

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

Rationale:

- Usable for public reporting.
- Requires additional guidance for radiologists in measure specifications.

Feasibility: <u>High-1, Moderate-7, Low-0, Insufficient-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)

Rationale:

- Concern regarding feasibility of collecting family history.
- Potential for unintended consequences due to repeat screening.

Steering Committee: <u>RECOMMEND FOR ENDORSEMENT</u>

Does the measure meet criteria for endorsement? <u>Preliminary Yes-9, No-3</u>

Rationale: The Committee notes considerable opportunity for improvement and need for assessment of disparities.

If Applicable, Conditions/Questions for Measure Developer:

- Has Active Health considered the unintended consequences of repeat screening ("anytime in the past")? The Committee notes that data on repeat screening show little impact on mortality.
    - Committee's recommendation – revise specifications to explicitly state "one time in the past" instead of "anytime in the past".
- Committee's recommendation – the measure does not differentiate between the various reasons why men receive abdominal tests; therefore, the developers should develop consistent guidance for radiologists.
- What is the list of abdominal imaging allowed as "alternatives"?

Developer response:

- The specifications have been revised to explicitly state "one time in the past." Please see measure submission form.
- The measure is not specified toward the radiologist's reading of an imaging study, but gives credit to those physicians who have appropriately ordered specific abdominal imaging (ultrasound with view of the aorta, CT scan or MRI of the abdomen, etc.) for their patients with specific risk factors for AAA. It is assumed that the radiologist interpreting the imaging study, which specifically includes a view of the abdominal aorta, will comment if he or she sees an AAA. There is no entry section for this information on the submission form.
- We have attached the list of codes for the Abdominal Imaging elements with detailed descriptions, and similarly updated the online submission form.

Steering Committee Workgroup (following developer's response and/or modifications): <u>RECOMMEND FOR ENDORSEMENT</u>

Does the measure meet criteria for endorsement? <u>FINAL Yes-7; No-1</u>

Public & Member Comment
Comments included:

- Low prevalence among men – may be better to reclassify and move from population health to another topic area
- Small at-risk population-value added proposition
- Listing imaging studies would be helpful
- Concern regarding the feasibility of collection family history
- Concern about the potential unintended consequences due to repeat screening

NQF response: NQF is reviewing the measure classifications and this measure will likely be reassigned to another topic area in the future.

Developer response:

- This measure was initially tested on a smaller population. We expect that if run against a larger population, the denominator (i.e. the at- risk population) would also be larger and add to the value of this measure. Additionally, as data sources become more robust and enhancements are made in data ingestion processes, our expectation is that the performance gap of this measure will become more apparent.
- The rule algorithm which allows for various abdominal imaging studies to complete this measure. Within the numerator, the element named ABDOMINAL IMAGING Procedure includes, amongst other studies, CT and MRI.
- Patients with risk factors that are more easily identified, i.e., male patients greater than 65 years of age with a history of smoking, fulfill the denominator without needing to supply a family history.
- This measure only requires screening to be done one time and does not encourage repeat screening for AAA.

Committee response: The Committee had no additional comments and did not wish to change their recommendation.

Measure Deferred

0031 Breast Cancer Screening
Measure Submission Form **Description:** Percentage of eligible women 40-69 who receive a mammogram in a two year period **Numerator Statement:** One or more mammograms during the measurement year or the year prior to the measurement year **Denominator Statement:** Women 42–69 years of age **Adjustment/Stratification:** No risk adjustment or risk stratification **Exclusions:** Optional Exclusion: Women who had a bilateral mastectomy or for whom there is evidence of two unilateral mastectomies. **Measure Type:** Process **Data Source:** Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records **Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Health Plan **Measure Steward:** National Committee for Quality Assurance
STEERING COMMITTEE EVALUATION
Importance to Measure and Report: No Vote *(1a. Impact; 1b. Performance gap; 1c Evidence)* **Rationale:** • High impact and performance gap due to prevalence, high morbidity, and high mortality associated with breast cancer. • Concern regarding positive vs. negative consequences of false positives, particularly at lower age range. • Conflicting recommendations and controversy for women aged 40-50. The measure does not capture the shared-decision making. • USPSTF also recommends screening up to age 74.
Scientific Acceptability of Measure Properties: No Vote *(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk Adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h Disparities)* **Rationale:** • Recommend that data collection allows for age stratification. • Difficult to capture the individual decision-making via administrative data.
Usability: No Vote *(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to exiting measures)* **Rationale:** • Health plans are finding the controversy over age 40-49 difficult – some are measuring only 50 and older internally. • Potentially usable for both population health assessment and for plan/practitioner quality improvement efforts. • The “optional” exclusions are generally taken if the data are available.

Feasibility: No Vote

(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:

- Unintended consequences for women under 50 years.
- Required data elements for numerator, denominator and optional exclusion are available and already in use.
- Potential threat to availability of data electronically when members switch health plans

Steering Committee: MAINTENANCE DEFERRED

Does the measure meet criteria for endorsement? No Vote

Rationale:

- Committee discussed the inconsistency of current guidelines but also cautioned that the evidence on screening for all applicable age groups should be reviewed carefully and stratified to reveal important data about each age group. They added that there is significant evidence to support mammography for older age groups but conflicting evidence that assesses the balance of the benefits and harms in younger age groups.
- The measure developer advised the Committee that they are in the process of review and revision of this measure – specifically regarding stratification for age groups and the upper age limit. Expected completion is winter 2013.
- The revised specifications for the measure will be reviewed when available.

NQF response: This measure was deferred and was evaluated in NQF's Cancer Endorsement Maintenance 2011 project.

Measures Withdrawn From Consideration

The following five endorsed measures were not submitted by the developer for maintenance of endorsement evaluation:

0040 Flu Shots for Older Adults (NCQA)	The measure was combined with measure #039.
0044 Pneumonia Vaccination (NCQA)	The measure is no longer maintained by the developer.
0149 Influenza vaccination (CMS)	This measure is replaced by measure #1659.
0150 Pneumococcal vaccination (CMS)	This measure is replaced by measure #1653.
0227 Influenza immunization (PCPI)	This measure was withdrawn in favor of measure #226.

APPENDIX A: MEASURE SPECIFICATIONS

	Measure 0226: Influenza Immunization in the ESRD Population (Facility Level) (Kidney Care Quality Alliance)
Description	Percentage of end stage renal disease (ESRD) patients aged 6 months and older receiving hemodialysis or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31 who either received, were offered and declined, or were determined to have a medical contraindication to the influenza vaccine.
Numerator	Number of patients from the denominator who: 1. received an influenza vaccination* - documented by the provider or reported receipt from another provider by the patient (computed and reported separately); OR 2. were assessed and offered an influenza vaccination but declined (computed and reported separately); OR 3. were assessed and determined to have a medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, and/or bone marrow transplant within the past 6 months (<6 months prior to encounters between October 1 and March 31) (computed and reported separately). *Only inactivated vaccine should be used in the ESRD population.
Numerator Details	The necessary data elements are to be collected via the Centers for Medicare and Medicaid (CMS) CROWNWeb data repository when functional, as indicated by the measure's inclusion in CMS's list of Phase III ESRD Clinical Performance Measures in effect April 1, 2008. Include in the numerator all patients from the denominator who: 1. Received an influenza vaccination* (documented by the provider or reported receipt from another provider by the patient). CPT codes: • 90655 (Influenza virus vaccine, split virus, preservative free, when administered to 6–35 months) • 90656 (Influenza virus vaccine, split virus, preservative free, when administered to 3 years and older, for intramuscular use) • 90657 (Influenza virus vaccine, split virus, when administered to 6–35 months) • 90658 (Influenza virus vaccine, split virus, when administered to 3 years of age and older, for intramuscular use) 2. Were assessed and offered an influenza vaccination but declined. CPT II code 1030F (assessment of influenza immunization status). 3. Were assessed and were determined to have a medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, and/or bone marrow transplant within the past 6 months (<6 months prior to encounters between October 1 and March 31). CPT II codes: • 1030F (assessment of influenza immunization status) • 4037F-1P, 4274F-1P, 4037F-2P, 4274F-2P (Influenza vaccine not received [appendage modifiers to CPT Category II codes]) *Only inactivated vaccine should be used in the ESRD population.
Denominator	All ESRD patients aged 6 months and older receiving hemodialysis and/or peritoneal dialysis during the time from October 1 (or when the influenza vaccine became available) to March 31.

Denominator Details	The necessary data elements are to be collected via the CMS CROWNWeb data repository when functional, as indicated by the measure´s inclusion in CMS's list of Phase III ESRD Clinical Performance Measures in effect April 1, 2008. Include in the denominator all patients within a facility who meet the following criteria during the time from October 1 (or when the influenza vaccine became available) to March 31 of the reporting year: 1. Diagnosis = ESRD (ICD-9 code 585.6; ICD-10 N18.0) AND 2. Primary type of dialysis = hemodialysis, home hemodialysis, continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), or nighttime intermittent peritoneal dialysis (NIPD). (CPT codes 90935, 90937, 90945, 90947, 90951-90970) AND 3. Age = >6 months
Exclusions	None.
Exclusion details	Not applicable.
Risk Adjustment	Other Not Applicable
Stratification	Not applicable.
Numerator Time window	October 1 (or when the influenza vaccine became available) to March 31 of the reporting year.
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records
Level	Facility
Setting	Dialysis Facility

	Measure 0031: Breast Cancer Screening (National Committee for Quality Assurance)
Description	Percentage of eligible women 40-69 who receive a mammogram in a two year period
Numerator	One or more mammograms during the measurement year or the year prior to the measurement year.
Numerator Details	Administrative Specification A woman had a mammogram if a submitted claim/encounter contains any of the following codes. Codes to Identify Breast Cancer Screening: CPT: 76090-76092, 77055-77057, G0202, G0204, G0206, V76.11, V76.12 87.36, 87.37 0401, 0403 Medical Record Specification One or more mammograms during the measurement year or the year prior to the measurement year. The medical record must include the following documentation. • A note indicating the date when the mammogram was performed, and • The result or finding
Denominator	Women 42–69 years of age
Denominator Details	Product lines: Commercial, Medicaid, Medicare (report each product line separately) Ages: Women 42-69 years as of December 31 of the measurement year Continuous Enrollment: The measurement year and the year prior to the measurement year Allowable gap: No more than one gap of enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment. Anchor date: December 31 of the measurement year Benefit: Medical Event/diagnosis: None. Medical Record Specification A systematic sample drawn from the eligible population. Use the Medical Record Method or the Hybrid Method to identify the eligible population. Refer to the following sections in the General Guidelines. • The Medical Record Method • The Hybrid Method • Sampling Methods
Exclusions	Optional Exclusion: Women who had a bilateral mastectomy or for whom there is evidence of two unilateral mastectomies.

Exclusion details	Table BCS-B: Codes to Identify Exclusions Bilateral mastectomy CPT: 19180, 19200, 19220, 19240, 19303-19307WITH Modifier .50 or modifier code 09950* ICD-9-CM Procedure: 85.42, 85.44, 85.46, 85.48 Unilateral mastectomy (members must have 2 separate occurrences on 2 different dates of service) CPT: 19180, 19200, 19220, 19240, 19303-19307 ICD-9-CM Procedure: 85.41, 85.43, 85.45, 85.47 *.50 and 09950 modifier codes indicate the procedure was bilateral and performed during the same operative session. Note: The purpose of this measure is to evaluate primary screening. Do not count biopsies, breast ultrasounds or MRIs for this measure because they are not appropriate methods for primary breast cancer screening.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A
Numerator Time window	December 31 of the measurement year.
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records
Level	Clinician : Group/Practice, Clinician : Individual, Health Plan
Setting	Ambulatory Care : Clinician Office

	Measure 0032: Cervical Cancer Screening (National Committee for Quality Assurance)
Description	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.
Numerator	One or more Pap tests during the measurement year (one calendar year) or the two years prior to the measurement year.
Numerator Details	ADMINISTRATIVE SPECIFICATION: Evidence of a Pap test is a submitted claim/encounter containing any of the following codes. Codes to Identify Cervical Cancer Screening CPT: 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175 HCPCS: G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 ICD-9-CM Diagnosis: V72.32, V76.2 ICD-9-CM Procedure: 91.46 UB Revenue: 0923 LOINC: 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5 MEDICAL RECORD SPECIFICATION: One or more Pap tests during the measurement year or the two years prior to the measurement year. Documentation in the medical record must include: • A note indicating the date when the test was performed, AND • The result or finding. Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening. Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening. NOTE: Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test.
Denominator	Women 24-64 years of age. For commercial plans, this includes the measurement year and the two years prior to the measurement year. For Medicaid plans, this includes the measurement year.
Denominator Details	Product lines - Commercial, Medicaid (report each product line separately). Ages - Women 24–64 years as of December 31 of the measurement year. Continuous enrollment Commercial: The measurement year and the two years prior to the measurement year. Medicaid: The measurement year. Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). Anchor date December 31 of the measurement year. Benefit Medical. Event/diagnosis None. Medical Record Specification A systematic sample drawn from the eligible population. Use the Medical Record Method or the Hybrid Method to identify the eligible population. Refer to the following sections in the General Guidelines. • The Medical Record Method • The Hybrid Method • Sampling Methods
Exclusions	Optional Exclusion: Women who had a hysterectomy with no residual cervix.

Exclusion details	ADMINISTRATIVE SPECIFICATION: Women who had a hysterectomy with no residual cervix. Look as far back as possible in the member's history for evidence of hysterectomy through December 31 of the measurement year. Refer to the following codes to identify a hysterectomy. Codes to Identify Exclusions CPT: 51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135 ICD-9-CM Diagnosis: 618.5, V67.01, V76.47, V88.01, V88.03 ICD-9-CM Procedure: 68.4-68.8 MEDICAL RECORD SPECIFICATION: Exclusionary evidence in the medical record must include a note indicating a hysterectomy with no residual cervix. The hysterectomy must have occurred by December 31 of the measurement year. Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy" meets exclusion criteria, but documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	None
Numerator Time window	December 31 of the measurement year.
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records
Level	Clinician : Group/Practice, Clinician : Individual, Health Plan
Setting	Ambulatory Care : Clinician Office

	Measure 0034: Colorectal Cancer Screening (National Committee for Quality Assurance)
Description	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.
Numerator	One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the four criteria below: •fecal occult blood test (FOBT) during the measurement year •flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year •double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year. •Colonoscopy during the measurement year or the nine years prior to the measurement year
Numerator Details	Appropriate screenings are defined by any one of the following criteria. • Fecal occult blood test (FOBT) during the measurement year. Regardless of FOBT type, guaiac (gFOBT) or immunochemical (iFOBT), assume that the required number of samples was returned. • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year • Double contrast barium enema (DCBE) or air contrast barium enema during the measurement year or the four years prior to the measurement year • Colonoscopy during the measurement year or the nine years prior to the measurement year There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance. • If the medical record does not indicate the type of test and there is no indication as to how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator. • If the medical record does not indicate the type of test and the number of returned samples is specified, the member would only meet the screening criteria if the number of samples specified is greater than or equal to three samples. If the number of samples is less than three, the member does not meet the screening criteria for inclusion in the numerator. • iFOBT tests may require fewer than three samples. If the medical record indicates that an iFOBT was done, the member meets the screening criteria for inclusion in the numerator regardless of the number of returned samples. • If the medical record indicates that a gFOBT was done, follow the scenarios below. – If the medical record does not indicate the number of returned samples, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator. – If the medical record indicates that three or more samples were returned, the member meets the screening criteria for inclusion in the numerator. – If the medical record indicates that fewer than three samples were returned, the member does not meet the screening criteria. FOBT: CPT codes (82270, 82274), HCPCS (G0328, G0394), ICD-9-CM Diagnosis (V76.51), LOINC (2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3) Flexible Signoidoscopy: CPT codes (45330-45335, 45337-45342, 45345), HCPCS codes (G0104), ICD-9-CM Procedure (45.24) Colonoscopy: CPT codes (44388-44394, 44397, 45355, 45378-45387, 45391, 45392), HCPCS codes (G0105, G0121), ICD-9-CM Procedure (45.22, 45.23, 45.25, 45.42, 45.43)
Denominator	Patients 51–75 years of age as of December 31 of the measurement year.

Denominator Details	Patients 51–75 years of age as of December 31 of the measurement year.
Exclusions	Patients with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the patient's history, through either administrative data or medical record review. Exclusionary evidence in the medical record must include a note indicating a diagnosis of colorectal cancer or total colectomy, which must have occurred by December 31 of the measurement year.
Exclusion details	Use the following codes or descriptions of the codes to identify allowable exclusions: Colorectal Cancer HCPCS codes (G0213-G0215, G0231) ICD-9-CM codes (153., 154.0, 154.1, 197.5, V10.05) Total colectomy CPT codes (44150-44153, 44155-44158, 44210-44212) ICD-9-CM codes (45.8)
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Measure is stratified by Commercial, Medicaid, and Medicare health plans.
Numerator Time window	• Fecal occult blood test (FOBT) during the measurement year. • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year • Double contrast barium enema (DCBE) or air contrast barium enema during the measurement year or the four years prior to the measurement year • Colonoscopy during the measurement year or the nine years prior to the measurement year
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Paper Records
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Health Plan
Setting	Ambulatory Care : Clinician Office

	Measure 0038: Childhood Immunization Status (National Committee for Quality Assurance)
Description	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B(HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.
Numerator	Children who have evidence showing they received recommended vaccines during the measurement year.
Numerator Details	Children with evidence of the following. For MMR, hepatitis B, VZV and hepatitis A , count any of the following: •evidence of the antigen or combination vaccine, or •documented history of the illness, or •a seropositive test result for each antigen For DtaP, IPV, HiB, pneumococcal conjugate, rotavirus and influenza, count only: • Evidence of the antigen or combination vaccine. For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), find evidence of all of the antigens. • DTaP: at least four DTaP vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth. • IPV: at least three IPV vaccinations, with different dates of service on or before the child's second birthday. IPV administered prior to 42 days after birth cannot be counted. • MMR: at least one MMR vaccination, with different dates of service on or before the child's second birthday. • HiB: at least three HiB vaccinations, with different dates of service on or before the child's second birthday. IPV administered prior to 42 days after birth cannot be counted. • Hepatitis B: at least three hepatitis B vaccinations, with different dates of service on or before the child's second birthday. • VZV: at least one VZV vaccination, with a date of service falling on or before the child's second birthday. • Pneumoncoccal conjugate: At least four pneumococcal conjugate vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth. • Hepatitis A: two hepatitis A vaccinations, with different dates of service on or before the child's second birthday. • Rotavirus: the child must receive the required number of rotavirus vaccinations on different dates or service on or before the second birthday. Do not count a vaccination administered prior to 42 days after birth. The following vaccine combinations are compliant: two doses of the two-dose vaccine; one dose of the two-dose vaccine and two doses of the three-dose vaccine; or three doses of the three-dose vaccine. • Influenza: two influenza vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to six months after birth. For immunization information obtained from the medical record, count patients where there is evidence that the antigen was rendered from: •a note indicating the name of the specific antigen and the date of the immunization, or •a certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. For documented history of illness or a seropositive test result, find a note indicating the date of the event. The event must have occurred by the patient's second birthday.

	Notes in the medical record indicating that the patient received the immunization “at delivery” or “in the hospital” may be counted toward the numerator. This applies only to immunizations that do not have minimum age restrictions (e.g., prior to 42 days after birth). A note that the “patient is up-to-date” with all immunizations that does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for this measure. Immunizations documented using a generic header or “DTaP/DTP/DT” can be counted as evidence of DTaP. The burden on organizations to substantite the DTaP antigen is excessive compared to a risk associated with data integrity. For rotavirus, if documentation does not indicate whether the two-dose schedule or three-dose schedule was used, assume a three-dose schedule and find evidence that three doses were administered. DTaP CPT: 90698, 90700, 90721, 90723 ICD-9-CM Procedure: 99.39 IPV CPT: 90698, 90713, 90723 ICD-9-CM Procedure: 99.41 MMR CPT: 90707, 90710 ICD-9-CM Procedure: 99.48 Measles and rubella CPT: 90708 Measles: CPT: 90705 ICD-9-CM Diagnosis: 055 ICD-9-CM Procedure: 99.45 Mumps CPT: 90704 ICD-9-CM Diagnosis: 072 ICD-9-CM Procedure: 99.46 Rubella CPT: 90706 ICD-9-CM Diagnosis: 056 ICD-9-CM Procedure: 99.47 HiB CPT: 90645-90648, 90698, 90721, 90748 Hepatitis B CPT: 90723, 90740, 90744, 90747, 90748 HCPCS: G0010 ICD-9-CM Diagnosis: 070.2, 070.3, V02.61 VZV CPT: 90710, 90716 ICD-9-CM Diagnosis: 052, 053

	Pneumococcal conjugate CPT: 90669, 90670 HCPCS: G0009 Hepatitis A CPT: 90633 ICD-9-CM Diagnosis: 070.0, 070.1 RotaVirus (two dose schedule) CPT: 90681 RotaVirus (three dose schedule) CPT: 90680 Influenza: CPT: 90655, 90657, 90661, 90662 HCPCS: G0008 ICD-9-CM Procedure: 99.52
Denominator	Children who turn 2 years of age during the measurement year are eligible for inclusion.
Denominator Details	Children who turn 2 years of age during the measurement year who are enrolled in a health plan 12 months prior to the child's second birthday. The child must be continuously enrolled in a health plan for 12 months prior to the child's second birthday. Allowable gap: No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Exclusions	Children who had a contraindication for a specific vaccine may be excluded from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. An organization that excludes contraindicated children may do so only if the administrative data do not indicate that the contraindicated immunization was rendered. The exclusion must have occurred by the second birthday. Organizations should look for exclusions as far back as possible in the member's history. Individuals diagnosed with HIV. Look for evidence of HIV diagnosis as far back as possible in the member´s history through December 31 of the measurement year. Individuals who have a diagnosis of pregnancy during the measurement year.
Exclusion details	Any particular vaccine: Anaphylactic reaction to the vaccination (ICD-9-CM, 999.4) DTaP: Emsephalopathy (ICD-9-CM 323.51 with E948.4 or E948.5 or E948.6); Progressive neurologic disorder, including infantile spasm, uncontrolled epilepsy. IPV: amaphylactic reaction to streptomycin, polymyxin B or neomycin MMR, VZV and influenza: immunodeficiency, including genetic (congenital) immuno-deficiency syndromes (ICD-9-CM 279); HIV disease or asymptomatic HIV (ICD-9-CM 042, V08); Cancer of lymphoreticular or histiocytic tissue (ICD-9-CM 200-202); Multiple myeloma (ICD-9-CM 203); Leukemia (ICD-9-CM 204-208); anaphylactic reaction to neomycin Hepatitis B: anaphylactic reaction to common baker's yeast
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Reported by Commercial and Medicaid plans.

Numerator Time window	2 years
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data : Registry, Paper Records
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Health Plan, Integrated Delivery System
Setting	Ambulatory Care : Clinician Office

	Measure 0039: Flu Shots for Adults Ages 50 and Over (National Committee for Quality Assurance)
Description	This measure represents the percentage of adults aged 50 and over who received an influenza vaccine within the measurement period within the respective age-stratified CAHPS surveys. This measure is only reported by age group stratification. The terms FSA and FSO, defined below, will be used to identify any differences between the two age stratifications. FSA - A rolling average represents the percentage of members 50–64 years of age who received an influenza vaccination between September 1 of the measurement year and the date on which the CAHPS 4.0H adult survey was completed. FSO - The percentage of Medicare members 65 years of age and older who received an influenza vaccination between September 1 of the measurement year and the date on which the Medicare CAHPS survey was completed.
Numerator	The number of patients in the denominator who responded, "Yes" to the question "Have you had a flu shot since September 1,YYYY? *YYYY = the measurement year (2010 for the survey fielded in 2011).
Numerator Details	No codes are used to collect the numerator for the survey measure.
Denominator	FSO (65+) – The number of members who responded "Yes" or "No" to the question, "Have you had a flu shot since September 1, YYYY?" FSA (50-64) – The number of members with a Flu Shots for Adults Ages 50-64 Eligibility Flag of "Eligible" who responded "Yes" or "No" to the question "Have you had a flu shot since September 1, YYYY?" *YYYY = the measurement year (2010 for the survey fielded in 2011).
Denominator Details	FSA (50-64) – The health plan assigns a Flu Shots for Adults Ages 50–64 Eligibility Flag for each member in the CAHPS 4.0H adult survey sample frame data file. Flu Shots for Adults Ages 50–64 Eligibility Flag 1 = Eligible (the member was born on or between September 2, 1945, and September 1, 1960) 2 = Ineligible (the member was born before September 2, 1945, or after September 1, 1960) The Flu Shots for Adults Ages 50–64 Eligibility Flag identifies the population eligible for the Flu Shots for Adults Ages 50–64 measure. NCQA calculates the results using responses from respondents with a flag of "1 = Eligible." The use of an eligibility flag protects member confidentiality (using the date of birth could result in a breach of confidentiality). FSO (65+) - Collected by CMS using the Medicare CAHPS Survey.
Exclusions	Does not meet age criteria.
Exclusion details	
Risk Adjustment	No risk adjustment or risk stratification
Stratification	
Numerator Time window	Currently enrolled at the time the survey is completed.
Type	Process
Type of Score	Other FSA - Rolling Average Methodology, FSO - Rate
Data Source	Paper Records
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Health Plan, Integrated Delivery System

Setting	Ambulatory Care : Clinician Office, Hospital/Acute Care Facility, Pharmacy, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation

	Measure 0041: Influenza Immunization (American Medical Association - Physician Consortium for Performance Improvement)
Description	Percentage of patients aged 6 months and older seen for a visit between October 1 and the end of February who received an influenza immunization OR patient reported previous receipt of an influenza immunization
Numerator	Patients who received an influenza immunization OR who reported previous receipt* of influenza immunization *Previous receipt can include: receipt of influenza immunization from another provider OR receipt of influenza immunization from same provider during a visit prior to October 1
Numerator Details	For Electronic Health Record specifications - See attached for PCPI eSpecification For Claims/Administrative specifications - • Report CPT Category II Code 4274F: Influenza immunization administered or previously received OR • CPT Procedure Code for Influenza Immunization: • 90655, 90656, 90657, 90658 • 90660, 90661, 90662, 90663, 90664 • 90666, 90667, 90668
Denominator	All patients aged 6 months and older seen for a visit between October 1 and the end of February

Denominator Details	For Electronic Health Record specifications - See attached for PCPI eSpecification For Claims/Administrative: Patients aged 6 months and older AND CPT code: One outpatient visit between October 1 and the end of February (October prior to the start of the measurement period, and the end of February of the measurement period if using a calendar year for the 12-month measurement period) • 99201, 99202, 99203, 99204, 99205 • 99212, 99213, 99214, 99215 • 99241, 99242, 99243, 99244, 99245 • 99304, 99305, 99306, 99307, 99308, 99309, 99310 • 99315, 99316 • 99324, 99325, 99326, 99327, 99328 • 99334, 99335, 99336, 99337 • 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 OR One dialysis visit between October 1 and the end of February • 90935, 90937, 90940 • 90945, 90947 • 90951, 90952, 90953 • 90954, 90955, 90956 • 90957, 90958, 90959 • 90960, 90961, 90962 • 90963, 90964, 90965, 90966 • 90967, 90968, 90969, 90970 • 90989, 90993, 90997, 90999 OR One preventive care visit between October 1 and the end of February • 99381, 99382, 99383, 99384, 99385, 99386, 99387 • 99391, 99392, 99393, 99394, 99395, 99396, 99397 • 99401, 99402, 99403, 99404 • 99411, 99412
Exclusions	Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reason) Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reason) Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reason)
Exclusion details	For Electronic Health Record specifications - See attached for PCPI eSpecification For Claims/Administrative specifications, For Claims/Administrative: Append modifier to CPT Category II code: 4274F-1P Append modifier to CPT Category II code: 4274F-2P Append modifier to CPT Category II code: 4274F-3P

Risk Adjustment	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Numerator Time window	Once during the measurement period
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Dialysis Facility, Home Health, Other:Domiciliary, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

	Measure 0046: Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older (National Committee for Quality Assurance)
Description	Percentage of female patients aged 65 years and older who have a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months.
Numerator	Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months
Numerator Details	3095F: CPT Category II code: 3095F – Central Dual-energy X-Ray Absorptiometry (DXA) results documented, OR 3096F: Central Dual- energy X-Ray Absorptiometry (DXA) ordered, OR 4005F: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed
Denominator	All female patients aged 65 years and older
Denominator Details	All female patients aged 65 years and older, AND Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
Exclusions	Except patients for whom central DXA measurement was not ordered or performed and pharmacologic therapy was not prescribed by reason of appropriate denominator exception, including Documentation of medical reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy Documentation of patient reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy Documentation of system reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy
Exclusion details	3096F or 3095F or 4005F with 1P: Documentation of medical reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis 3096F or 3095F or 4005F with 2P: Documentation of patient reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis 3096F or 3095F or 4005F with 3P: Documentation of system reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A
Numerator Time window	At least once within 12 months
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Ambulatory Care : Clinician Office

	Measure 0043: Pneumonia vaccination status for older adults (National Committee for Quality Assurance)
Description	Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination
Numerator	The number of patients in the denominator who responded "Yes" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in the person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."
Numerator Details	No codes are used to collect the numerator for the survey measure.
Denominator	The number of members who responded "Yes" or "No" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."
Denominator Details	Collected by CMS using the Medicare CAHPS Survey. No codes are used to collect the denominator information.
Exclusions	Does not meet age criteria
Exclusion details	
Risk Adjustment	No risk adjustment or risk stratification
Stratification	
Numerator Time window	Currently enrolled at the time the survey is completed.
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Healthcare Provider Survey, Paper Records, Patient Reported Data/Survey
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Health Plan, Integrated Delivery System, Population : County or City
Setting	Ambulatory Care : Clinician Office, Home Health, Hospital/Acute Care Facility, Pharmacy, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation

	Measure 0431: Influenza Vaccination Coverage Among Healthcare Personnel (Centers for Disease Control and Prevention)
Description	Percentage of healthcare personnel (HCP) who receive the influenza vaccination.
Numerator	HCP in the denominator population who during the time from October 1 (or when the vaccine became available) through March 31 of the following year: (a) received an influenza vaccination administered at the healthcare facility, or reported in writing (paper or electronic) or provided documentation that influenza vaccination was received elsewhere; or (b) were determined to have a medical contraindication/condition of severe allergic reaction to eggs or to other component(s) of the vaccine, or history of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination; or (c) declined influenza vaccination; or (d) persons with unknown vaccination status or who do not otherwise meet any of the definitions of the above-mentioned numerator categories. Numerators are to be calculated separately for each of the above groups.
Numerator Details	1. Persons who declined vaccination because of conditions other than those specified in the 2nd numerator category above should be categorized as declined vaccination. 2. Persons who declined vaccination and did not provide any other information should be categorized as declined vaccination. 3. Persons who did not receive vaccination because of religious exemptions should be categorized as declined vaccination. 4. Persons who deferred vaccination all season should be categorized as declined vaccination. 5. The numerator categories are mutually exclusive. The sum of the four numerator categories should be equal to the denominator.
Denominator	Number of HCP who are working in the healthcare facility for at least 30 working days between October 1 and March 31 of the following year, regardless of clinical responsibility or patient contact. Denominators are to be calculated separately for: (a) Employees: all persons who receive a direct paycheck from the reporting facility (i.e., on the facility's payroll). (b) Licensed independent practitioners: include physicians (MD, DO), advanced practice nurses, and physician assistants only who are affiliated with the reporting facility who do not receive a direct paycheck from the reporting facility. (c) Adult students/trainees and volunteers: include all adult students/trainees and volunteers who do not receive a direct paycheck from the reporting facility.
Denominator Details	1. Include all HCP in each of the three denominator categories who have worked at the facility between October 1 and March 31 for at least 30 working days. This includes persons who joined after October 1 or who left before March 31, or who were on extended leave during part of the reporting period. Working for any number of hours in a day should be counted as a working day. 2. Include both full-time and part-time persons. If a person works in two or more facilities, each facility should include the person in their denominator. 3. Count persons as individuals rather than full-time equivalents. 4. Licensed practitioners who receive a direct paycheck from the reporting facility, or who are owners of the reporting facility, should be counted as employees. 5. The denominator categories are mutually exclusive. The numerator data are to be reported separately for each of the three denominator categories.
Exclusions	None.

Exclusion details	Not applicable.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	The measure should be calculated separately for each denominator group of healthcare personnel: employees; licensed independent practitioners; and adult students/trainees and volunteers. Definitions for these groups are as follows: (a) Employees: all persons who receive a direct paycheck from the reporting facility (i.e., on the facility's payroll). (b) Licensed independent practitioners: include physicians (MD, DO), advanced practice nurses, and physician assistants only who are affiliated with the reporting facility and do not receive a direct paycheck from the reporting facility. (c) Adult students/trainees and volunteers: include all adult students/trainees and volunteers who do not receive a direct paycheck from the reporting facility.
Numerator Time window	HCP are eligible for inclusion in the numerator from October 1 (or the time influenza vaccine becomes available, whichever is sooner) to March 31 of the following year.
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Clinical Data, Management Data, Paper Records, Patient Reported Data/Survey
Level	Facility
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Dialysis Facility, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

	Measure 0522: Influenza Immunization Received for Current Flu Season (Home Health) (Centers for Medicare & Medicaid Services)
Description	Percentage of home health episodes of care during which patients received influenza immunization for the current flu season.
Numerator	Number of home health episodes of care during which the patient a) received vaccination from the HHA or b) had received vaccination from HHA during earlier episode of care, or c) was determined to have received vaccination from another provider. NOTE: Number of home health episodes of care during which the patient was offered and refused vaccine; AND Number of home health episodes of care during which the patient was determined to have medical contraindication(s) are computed separately and reported to agencies but are not reported publicly.
Numerator Details	Measure specifications follow National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations, Final Deliverable to CMS under Contract # HHSM-500-2006-00027I – Task Order 0008: Adult Immunizations, published September 15, 2008 Numerator is based on responses to items in the OASIS-C data set as follows: Number of home health patient episodes of care where at end of episode: -(M1040) Influenza Vaccine Rec'd = 1 (yes) or -(M1045) Reason Influenza Vaccine not Rec'd = 1 (Rec'd from another provider), or -(M1045) Reason Influenza Vaccine not Rec'd = 2 (Rec'd previously from agency during this year's flu season)
Denominator	Number of home health episodes of care ending during the reporting period, other than those covered by generic or measure-specific exclusions.
Denominator Details	Number of home health patient episodes of care, defined as: A start/resumption of care assessment ((M0100) Reason for Assessment = 1 (Start of care) or 3 (Resumption of care)) paired with a corresponding discharge/transfer assessment ((M0100) Reason for Assessment = 6 (Transfer to inpatient facility – not discharged), 7 (Transfer to inpatient facility – discharged), 8 (Death at home), or 9 (Discharge from agency)), other than those covered by denominator exclusions.
Exclusions	Episodes which do not include any days during the flu season (October 1 - March 31). Episodes which ended with patient death. Episodes in which the patient does not meet the CDC guidelines for influenza vaccine.

Exclusion details	Measure Specific Exclusions: Number of home health patient episodes of care where at end of episode: - (M0100) Reason for Assessment = 8 (Death at home) PLUS Number of home health patient episodes of care where at end of episode: - (M0100) Reason for Assessment = 6 or 7 (transfer to inpatient) or 9 (discharge) AND: - (M1055) Reason Influenza Vaccine not Rec'd = 5 (not indicated, patient does not meet age/condition guidelines) PLUS Number of home health patient episodes of care where (M0030) Start of Care Date or (M0032) Resumption of Care Date, and (M0906) Discharge/Transfer Date indicate no part of episode occurred during flu season (October 1 to March 31) Generic Exclusions: Medicare-certified home health agencies are currently required to collect and submit OASIS data only for adult (aged 18 and over) non-maternity Medicare and Medicaid patients who are receiving skilled home health care. Therefore, maternity patients, patients less than 18 years of age, non-Medicare/Medicaid patients, and patients who are not receiving skilled home services are all excluded from the measure calculation. However, the OASIS items and related measures could potentially be used for other adult patients receiving services in a community setting, ideally with further testing. The publicly-reported data on CMS' Home Health Compare web site also repress cells with fewer than 20 observations, and reports for home health agencies in operation less than six months.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A - not stratified.
Numerator Time window	CMS systems report data on episodes that include at least one day between October 1 and March 31, inclusive, and that end within a rolling 12 month period, updated quarterly.
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Clinical Data
Level	Facility
Setting	Home Health

	Measure 0525: Pneumococcal Polysaccharide Vaccine (PPV) Ever Received (Home Health) (Centers for Medicare and Medicaid Services, Office of Clinical Standards and Quality, Quality Measurement and Health Assessment Group)
Description	Percentage of home health episodes of care during which patients were determined to have ever received Pneumococcal Polysaccharide Vaccine (PPV).
Numerator	Number of home health episodes of care during which patients were determined to have ever received Pneumococcal Polysaccharide Vaccine (PPV).
Numerator Details	Measure specifications follow National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations, Final Deliverable to CMS under Contract # HHSM-500-2006-00027I – Task Order 0008: Adult Immunizations, published September 15, 2008 Numerator is based on responses to items in the OASIS-C data set as follows: Number of home health patient episodes of care where at end of episode: - (M1050) PPV Rec'd = 1 (yes) OR - (M1055) PPV not Rec'd = 1 (Rec'd in past)
Denominator	Number of home health episodes of care ending during the reporting period, other than those covered by generic or measure-specific exclusions.
Denominator Details	Number of home health patient episodes of care, defined as: A start/resumption of care assessment ((M0100) Reason for Assessment = 1 (Start of care) or 3 (Resumption of care)) paired with a corresponding discharge/transfer assessment ((M0100) Reason for Assessment = 6 (Transfer to inpatient facility – not discharged), 7 (Transfer to inpatient facility – discharged), 8 (Death at home), or 9 (Discharge from agency)), other than those covered by denominator exclusions.
Exclusions	Episodes which ended in patient death. Episodes in which the patient does not meet the CDC age/condition guidelines for PPV vaccine.
Exclusion details	Measure-specific exclusions: Number of home health patient episodes of care where at end of episode: - (M0100) Reason for Assessment = 8 (death at home) PLUS Number of home health patient episodes of care where at end of episode: - (M0100) Reason for Assessment = 6 or 7 (transfer to inpatient) or 9 (discharge) AND: (M1055) PPV not Rec'd = 4 (not indicated, patient does not meet age/condition guidelines) Generic Exclusions: Medicare-certified home health agencies are currently required to collect and submit OASIS data only for adult (aged 18 and over) non-maternity Medicare and Medicaid patients who are receiving skilled home health care. Therefore, maternity patients, patients less than 18 years of age, non-Medicare/Medicaid patients, and patients who are not receiving skilled home services are all excluded from the measure calculation. However, the OASIS items and related measures could potentially be used for other adult patients receiving services in a community setting, ideally with further testing. The publicly-reported data on CMS' Home Health Compare web site also repress cells with fewer than 20 observations, and reports for home health agencies in operation less than six months.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A
Numerator Time window	CMS systems report data on episodes that end within a rolling 12 month period, updated quarterly.
Type	Process
Type of Score	Rate/proportion

Data Source	Electronic Clinical Data
Level	Facility
Setting	Home Health

	Measure 0579: Annual cervical cancer screening or follow-up in high-risk women (Resolution Health, Inc.)
Description	This measure identifies women age 12 to 65 diagnosed with cervical dysplasia (CIN 2), cervical carcinoma-in-situ, or HIV/AIDS prior to the measurement year, and who still have a cervix, who had a cervical CA screen during the measurement year.
Numerator	Patients in the denominator who had a cervical CA screen during the measurement year
Numerator Details	>=1 procedure claim for a cervical cancer screen during the measurement year. Codes with descriptors: ´0923 Other Diagnostic Services HSREV ´88141 CYTOPATH C/V INTERPRET CPT4 ´88142 CYTOPATH C/V THIN LAYER CPT4 ´88143 CYTOPATH CERV/VAG; W/MNL SCR-RESCR CPT4 ´88147 CYTOPATH C/V AUTOMATED CPT4 ´88148 CYTOPATH C/V AUTO RESCREEN CPT4 ´88150 CYTOPATH C/V MANUAL CPT4 ´88152 CYTOPATH C/V AUTO REDO CPT4 ´88153 CYTOPATH C/V REDO CPT4 ´88154 CYTOPATH C/V SELECT CPT4 ´88155 CYTOPATH C/V INDEX ADD-ON CPT4 ´88164 CYTOPATH TBS C/V MANUAL CPT4 ´88165 CYTOPATH TBS C/V REDO CPT4 ´88166 CYTOPATH TBS C/V AUTO REDO CPT4 ´88167 CYTOPATH TBS C/V SELECT CPT4 ´88174 CYTOPATH C/V AUTO IN FLUID CPT4 ´88175 CYTOPATH C/V AUTO FLUID REDO CPT4 ´9146 CELL BLK&PAP SMER SPEC FE GNT TRACT ICD9P ´G0101 CERV/VAG CANCR SCR;PELV&CLN BRST EX HCPCS ´G0123 SCR CERV/VAG THIN LAY W/PHYS SUP HCPCS ´G0124 SCR CERV/VAG THIN LAY PHYS INTERP HCPCS ´G0141 SCR CERV/VAG MNL RSCR PHYS INTERP HCPCS ´G0143 SCR CERV/VAG MNL SCR/RSCR UND PHYS HCPCS ´G0144 SCR CERV/VAG SCR AUTO UND PHYS HCPCS ´G0145 SCR CERV/VAG AUTO&MNL RSCR PHYS HCPCS ´G0147 SCR SMEARS CERV/VAG AUTO UND PHYS HCPCS ´G0148 SCR SMEARS CERV/VAG MNL RESCR HCPCS ´P3000 SCR PAP SMER UP TO 3 TECH W/MD SUPV HCPCS ´P3001 SCR PAP SMER UP TO 3 RQR INTEPR MD HCPCS ´Q0091 SCR PAP SMER; OBTAIN PREP&CONVY-LAB HCPCS ´V7232 ENCOUNTR PAP CONFRM NL SMER FLW ABN ICD9 ´V762 SCREENING MALIGNANT NEOPLASM CERVIX ICD9
Denominator	Women who are 12-65 years of age who have a diagnosis of cervical dysplasia (CIN 2), cervical carcinoma-in-situ, or HIV/AIDS diagnosed prior to the measurement year, and who still have a cervix (excludes women with a hysterectomy and no residual cervix).

Denominator Details	- Age >12 and <65 years old as of the end of the measurement year - AND female - AND at least 1 claim prior to the measurement year for 1 or more of the following diagnoses: - cervical dysplasia (CIN 2), or - cervical carcinoma in-situ (CIN 3), or - HIV/AIDS, or - DES exposure in Utero, or - Transplant, or - Transplant Status - And eligible for service benefits for 2 years preceding the end of the measurement year Codes with descriptors: "CERVICAL CIS" ´2331 CARCINOMA IN SITU OF CERVIX UTERI ICD9 "CERVICAL DYSPLASIA" ´62210 DYSPLASIA OF CERVIX UNSPECIFIED ICD9 ´62211 MILD DYSPLASIA OF CERVIX ICD9 ´62212 MODERATE DYSPLASIA OF CERVIX ICD9 "DES EXPOSURE IN UTERO" ´76076 NOX INFLU FETUS/NB PLACNTA/BRST DES ICD9 "HIV AIDS" ´042 HUMAN IMMUNODEFICIENCY VIRUS [HIV] ICD9 ´07953 HIV TYPE 2 IN CCE & UNS SITE ICD9 ´V08 ASYMPTOMATIC HIV INFECTION STATUS ICD9 "TRANSPLANT" ´00580 ANESTH HEART/LUNG TRANSPLNT CPT4 ´00796 ANESTH FOR LIVER TRANSPLANT CPT4 ´00868 ANESTH KIDNEY TRANSPLANT CPT4 ´32851 LUNG TRANSPLANT SINGLE CPT4 ´32852 LUNG TRANSPLANT WITH BYPASS CPT4 ´32853 LUNG TRANSPLANT DOUBLE CPT4 ´32854 LUNG TRANSPLANT WITH BYPASS CPT4 ´335 LUNG TRANSPLANT ICD9P ´3350 LUNG TRANSPLANTATION NOS ICD9P ´3351 UNILATERAL LUNG TRANSPLANTATION ICD9P ´3352 BILATERAL LUNG TRANSPLANTATION ICD9P ´336 COMBINED HEART-LUNG TRANSPLANTATION ICD9P ´33935 TRANSPLANTATION HEART/LUNG CPT4 ´33945 TRANSPLANTATION OF HEART CPT4 ´3751 HEART TRANSPLANTATION ICD9P ´38240 BONE MARROW/STEM TRANSPLANT CPT4 ´38241 BONE MARROW/STEM CELL TRANSPL; AUTO CPT4 ´38242 BN MARROW/BLD STEM CELL TPLNT; ALLO CPT4 ´410 BONE MARROW TRANSPLANT ICD9P ´4100 BONE MARROW TRANSPLANT NOS ICD9P ´4101 AUTOL BN MARROW TPLNT W/O PURGING ICD9P ´4102 ALLOGENEIC MARROW TRANSPL-PURGE ICD9P

	´4103 ALLOGENEIC BONE MARROW TRANSPL ICD9P ´4104 AUTO HEMAT ST CELL TRNSPLT W/O PURG ICD9P ´4105 ALLO HEMAT ST CELL TRNSPLT W/O PURG ICD9P ´4106 CORD BLOOD STEM CELL TRANSPLANT ICD9P ´4107 AUTO HEMAT ST CELL TRNSPLT W PURG ICD9P ´4108 ALLO HEMAT STEM CELL TRNSPLT W/PURG ICD9P ´4109 AUTOL BN MARROW TPLNT W/PURGING ICD9P ´47135 LIVER ALLOTRANSPL; ORTHOTOP-PRT/ALL CPT4 ´47136 LIVER ALLOTRANSPL; HETEROTOPIC CPT4 ´47140 PARTIAL REMOVAL DONOR LIVER CPT4 ´48160 PANCREATECT W/TPLNT PANC/ISLET CELL CPT4 ´48554 TRANSPLANTATION PANCREATIC ALLOGFT CPT4 ´50360 RENAL ALLOTRANSPL;W/O DONR NEPHRECT CPT4 ´50365 RENAL ALLOTRANSPL; W/RECIP NEPHRECT CPT4 ´505 LIVER TRANSPLANT ICD9P ´5051 AUXILIARY LIVER TRANSPLANT ICD9P ´5059 OTHER TRANSPLANT OF LIVER ICD9P ´528 TRANSPLANT OF PANCREAS ICD9P ´5280 PANCREATIC TRANSPLANT NOS ICD9P ´5281 REIMPLANTATION OF PANCREATIC TISSUE ICD9P ´5282 HOMOTRANSPLANT OF PANCREAS ICD9P ´5283 HETEROTRANSPLANT OF PANCREAS ICD9P ´5284 AUTOTPLNT CELLS ISLETS LANGERHANS ICD9P ´5285 ALLOTPLNT CELLS ISLETS LANGERHANS ICD9P ´5286 TPLNT CELLS ISLETS LANGERHANS NOS ICD9P ´5569 OTHER KIDNEY TRANSPLANTATION ICD9P "TRANSPLANT STATUS" ´1992 MALIG NEOPLSM ASSOC TRANSPLNT ORGAN ICD9 ´9968 COMPLICATIONS OF TRANSPLANTED ORGAN ICD9 ´99680 COMPS TPLNT ORGAN UNSPEC SITE ICD9 ´99681 COMPLICATIONS TRANSPLANTED KIDNEY ICD9 ´99682 COMPLICATIONS OF TRANSPLANTED LIVER ICD9 ´99683 COMPLICATIONS OF TRANSPLANTED HEART ICD9 ´99684 COMPLICATIONS OF TRANSPLANTED LUNG ICD9 ´99685 COMPS BONE MARROW TRANSPLANT ICD9 ´99686 COMPLICATIONS TRANSPLANTED PANCREAS ICD9 ´99687 COMPS TRANSPLANTED ORGAN INTESTINE ICD9 ´99689 COMPS OTH TRANSPLANTED ORGAN ICD9 ´V42 ORGAN OR TISSUE REPLACED TRANSPLANT ICD9 ´V420 KIDNEY REPLACED BY TRANSPLANT ICD9 ´V421 HEART REPLACED BY TRANSPLANT ICD9 ´V426 LUNG REPLACED BY TRANSPLANT ICD9 ´V427 LIVER REPLACED BY TRANSPLANT ICD9 ´V428 OTH SPEC ORGN/TISS REPLCD TPLNT ICD9 ´V4281 BONE MARROW REPLACED BY TRANSPLANT ICD9 ´V4282 PERIPH STEM CELLS REPLCD TRANSPLANT ICD9 ´V4283 PANCREAS REPLACED BY TRANSPLANT ICD9 ´V4284 ORGN/TISS REPLCD TRANSPLANT INTEST ICD9 ´V4289 OTH ORGAN/TISSUE REPLCD TRANSPLANT ICD9 ´V429 UNSPEC ORGN/TISS REPLCD TRANSPLANT ICD9

Exclusions	No claims for cervical cancer screening exclusions, based on NCQA/HEDIS technical specifications: Women who had a hysterectomy with no residual cervix.
Exclusion details	"HYSTERECTOMY_HEDIS_D" ´6185 PROLAPSE VAGINAL VAULT AFTER HYST ICD9 ´V6701 FOLLOW SURG F/U VAGINAL PAP SMEAR ICD9 ´V7647 SPECIAL SCR MALIG NEOPLSM VAGINA ICD9
Risk Adjustment	No risk adjustment or risk stratification
Stratification	The measure specifications do not require the results to be stratified.
Numerator Time window	1 year.
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data : Pharmacy
Level	Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System, Population : Community, Population : County or City
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office

	Measure 0614: Steroid Use - Osteoporosis Screening (ActiveHealth Management)
Description	The percentage of patients, 18 and older, who have been on chronic steroids for at least 180 days in the past 9 months and who had a bone density evaluation or osteoporosis treatment
Numerator	Patients who have had a bone density evaluation or osteoporosis treatment.
Numerator Details	NUMERATOR: All of the following are correct: 1. Denominator is true 2. Osteoporosis Screening Anytime Validation (see below)is confirmed for the member Osteoporosis Screening Anytime Validation One of the following is correct: 1. Presence of at least 1 BONE MINERAL DENSITY STUDIES procedure in the past anytime 2. Presence of at least 1 BONE IMAGING-WHOLE BODY procedure in the past anytime 3. Presence of at least 1 refill OSTEOPOROSIS THERAPY in the past anytime 4. Presence of patient data confirming at least 1 PDD- OSTEOPOROSIS TREATMENT in the past anytime 5. Presence of patient data confirming at least 1 PDD- OSTEOPOROSIS in the past anytime 6. Presence of patient data confirming PDD- BONE DENSITY TEST in the past anytime 7. Presence of at least 1 OSTEOPOROSIS diagnosis in the past anytime 8. Presence of patient data confirming at least 1 refill OSTEOPOROSIS THERAPY drug in the past anytime 9. Presence of at least 1 ZOLEDRONIC ACID- RECLAST(CPT) procedure in the past anytime 10. Presence of at least 1 TERIPARATIDE (HCPCS) procedure in the past anytime 11. Presence of at least 1 OSTEOPOROSIS SCREENING (ICD9) Diagnosis in the past anytime Note: A 3-month window has been added to certain timeframes to account for the inherent delay in the acquisition of administrative claims data. Note: A current refill is defined as a refill in which the total day supply of a drug plus a grace period of an additional 30 days that extends into the end of the measurement window. See attached document for code sets
Denominator	Patients, 18 and older, who have been on chronic steroids for at least 180 days
Denominator Details	DENOMINATOR: All of the following are correct: 1. If patient age >= 18 2. One of the following is correct: a.Presence of STEROIDS >/ 5MG PREDNISONE 180 total days supply in the past 9 months b.Presence of patient data confirming at least 1 PDD- STEROID USE (6 MTHS OR MORE) in the past 6 months See attached for code set

Exclusions	Specific exclusions: - Pregnancy General exclusions: - Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months - Patients who have been in a skilled nursing facility in the last 3 months
Exclusion details	DENOMINATOR EXCLUSIONS All of the following is correct: 1. Pregnancy Loose Version Validation (see below)Rule is confirmed for the member Pregnancy Loose Version Validation One of the following is correct: 1. Presence of at least 1 HCG (LOINC) Labs Result Value >100 in the past 6 months 2. Presence of patient data confirming at least 1 PDD- PREGNANCY in the past 6 months 3. Presence of at least 1 PREGNANCY diagnosis in the past 6 months 4. Presence of at least 1 PREGNANCY RELATED PROCEDURE in the past 6 months 5. Presence of At Least 1 PREGNANCY EXCLUSION Diagnosis in the past 6 Months 6. Presence of At Least 1 PREGNANCY COMPLICATIONS Diagnosis in the past 6 Months 7. Presence of At Least 1 PREGNANCY INFECTION SCREENING Procedure In the past 6 Months 8. Presence of At Least 1 PREGNANCY HIGH RISK Diagnosis in the past 6 Months See attached for code set
Risk Adjustment	No risk adjustment or risk stratification
Stratification	No stratification
Numerator Time window	Anytime in the past
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry, Patient Reported Data/Survey
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Health Plan, Integrated Delivery System, Population : Community, Population : County or City, Population : National, Population : Regional, Population : State
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation

	Measure 0617: High Risk for Pneumococcal Disease - Pneumococcal Vaccination (ActiveHealth Management)
Description	The percentage of patients age 5-64 with a high risk condition, or age 65 years and older who: 1. Received a pneumococcal vaccine (reported separately) 2. Had a contraindication to pneumococcal vaccine(reported separately)
Numerator	Two separate numerators: 1. Patients who receive a pneumococcal vaccine 2. Patients who have a contraindication to pneumococcal vaccine
Numerator Details	Two separate numerators: A. NUMERATOR for High Risk for Pneumococcal Disease - Pneumococcal Vaccination The following is correct: 1. If Shared Common Rule Pneumococcal 23 Valent Vaccine Surrogates is confirmed (see below) Shared Common Rule Pneumococcal 23 Valent Vaccine Surrogates One of the following is correct: a. Presence of at least 1 refill VACCINE-PNEUMOCOCCAL-23 VALENT anytime in the past b. Presence of at least 1 VACCINE (ICD-9)-PNEUMOCOCCAL diagnosis anytime in the past c. Presence of at least 1 VACCINE-PNEUMOCOCCAL 23 VALENT procedure anytime in the past d. Presence of patient data confirming at least 1 PDD- VACCINE PPV-23 anytime in the past e. Presence of provider or patient feedback indicating that vaccine has already been implemented B. Numerator for High Risk for Pneumococcal Disease - Pneumococcal Vaccine Contraindications The following is correct: 1. If Shared Common Rule Pneumococcal Vaccine Contraindications is confirmed (see below) Shared Common Rule Pneumococcal Vaccine Contraindications One of the following is correct: 1. Presence of patient data confirming at least 1 PDD- Vaccine Pneumo Allergic anytime in the past 2. Presence of provider feedback indicating that vaccine is contraindicated Code Set NQF ID Numerator Element Name ATOM Description 617 Numerator *PDD- VACCINE PPV-23 AA2968.9515 Has your child received at least 2 different types of pneumonia vaccines? = Both vaccines 617 Numerator *PDD- VACCINE PPV-23 AA43.109 (Ages 2 -70)Have you received a pneumovax vaccine (pneumonia shot)? = Yes 617 Numerator *PDD- VACCINE PPV-23 ATV22186.82718 Have you received a pneumococcal vaccination? = Yes 617 Numerator *PDD- VACCINE PPV-23 ATV43.109 (Ages 2 -70)Have you received a pneumovax vaccine (pneumonia shot)? = Yes 617 Numerator *PDD- VACCINE PPV-23 AA12142.44915 Have you ever had a pneumonia vaccine shot (pneumococcal vaccine)? = Yes 617 Numerator *PDD- VACCINE PPV-23 ATV2968.9517 Has your child received at least 2 different types of pneumonia vaccines? = 1 vaccine - 23 valent 617 Numerator *PDD- VACCINE PPV-23 AA2968.9517 Has your child received at least 2 different types of pneumonia vaccines? = 1 vaccine - 23 valent 617 Numerator *PDD- VACCINE PPV-23 HMT38.1 Have you had a pneumonia shot in the past 5 years? = Yes 617 Numerator *PDD- VACCINE PPV-23 PHR200001023.1 Have you ever gotten the vaccine for pneumonia? = Yes

	617 Numerator *PDD- VACCINE PPV-23 ATV12142.44915 Have you ever had a pneumonia vaccine shot (pneumococcal vaccine)? = Yes 617 Numerator *PDD- VACCINE PPV-23 PHR200000078.1 The vaccine to help prevent pneumonia is given at least once depending on your age and conditions. How many times have you had this vaccine? = Once and it was in the past 5 years 617 Numerator *PDD- VACCINE PPV-23 PHR200000078.2 The vaccine to help prevent pneumonia is given at least once depending on your age and conditions. How many times have you had this vaccine? = Once and it was more than 5 years ago 617 Numerator *PDD- VACCINE PPV-23 ATV2968.9515 Has your child received at least 2 different types of pneumonia vaccines? = Both vaccines 617 Numerator *PDD- VACCINE PPV-23 GRDA73.1 Have you had a pneumonia shot (sometimes called Pneumovax) within the past 5 years? = Yes 617 Numerator *PDD- VACCINE PPV-23 PHR200000078.3 The vaccine to help prevent pneumonia is given at least once depending on your age and conditions. How many times have you had this vaccine? = Two or more times 617 Numerator *PDD- VACCINE PPV-23 AA22186.82718 Have you received a pneumococcal vaccination? = Yes 617 Numerator *PDD- VACCINE PPV-23 AA16000.60173 (Ages >70)Have you received a pneumovax vaccine (pneumonia shot) since turning 65 yrs old? = Yes 617 Numerator *PDD- VACCINE PPV-23 ATV16000.60173 (Ages >70)Have you received a pneumovax vaccine (pneumonia shot) since turning 65 yrs old? = Yes 617 Numerator *PDD- VACCINE PPV-23 GORD81.1 Have you had a pneumonia shot (sometimes called Pneumovax) within the past 5 years? = Yes 617 Numerator *VACCINE(ICD9)-PNEUMOCOCCAL V06.6 NEED PROPH VACCINATION W/STREP PNEUMONE&FLU 617 Numerator *VACCINE(ICD9)-PNEUMOCOCCAL V03.82 NEED PROPH VACCINATION AGAINST STREP PNEUMONE 617 Numerator *VACCINE-PNEUMOCOCCAL 23 VALENT 90732 PNEUMOCOCCAL POLYSAC VACCINE 23-V 2 YR + SUBQ/IM 617 Numerator *VACCINE-PNEUMOCOCCAL 23 VALENT G8115 PT DOCUMENTED TO HAVE RECEIVED PNEUMOCOCCAL VACC 617 Numerator *VACCINE-PNEUMOCOCCAL 23 VALENT G0009 Administration of pneumococcal vaccine 617 Numerator *VACCINE-PNEUMOCOCCAL 23 VALENT 4040F PNEUMOCOCCAL VACCINE ADMIN RCVD B/4 617 Numerator *VACCINE-PNEUMOCOCCAL-23 VALENT 54569141200 PNEUMOVAX 23 VIAL 617 Numerator *VACCINE-PNEUMOCOCCAL-23 VALENT 00006473950 PNEUMOVAX 23 VIAL 617 Numerator *VACCINE-PNEUMOCOCCAL-23 VALENT 00006489400 PNEUMOVAX 23 SYRINGE 617 Numerator *VACCINE-PNEUMOCOCCAL-23 VALENT 54868070700 PNU-IMUNE 23 VIAL 617 Numerator *VACCINE-PNEUMOCOCCAL-23 VALENT 00006494300 PNEUMOVAX 23 VIAL 617 Numerator *VACCINE-PNEUMOCOCCAL-23 VALENT 54868333901 PNEUMOVAX 23 VIAL

	617 Numerator *VACCINE-PNEUMOCOCCAL-23 VALENT 00005230931 PNU-IMUNE 23 VIAL 617 Numerator *VACCINE-PNEUMOCOCCAL-23 VALENT 54569272000 PNEUMOVAX 23 VIAL 617 Numerator *VACCINE-PNEUMOCOCCAL-23 VALENT 00005230933 PNU-IMUNE 23 SYRINGE 617 Numerator *VACCINE-PNEUMOCOCCAL-23 VALENT 54868432000 PNEUMOVAX 23 VIAL 617 Numerator *VACCINE-PNEUMOCOCCAL-23 VALENT 00006474100 PNEUMOVAX 23 VIAL 617 Numerator *VACCINE-PNEUMOCOCCAL-23 VALENT 00006473900 PNEUMOVAX 23 VIAL 617 Numerator *PDD- VACCINE PNEUMO ALLERGIC AA43.70139 (Ages 2 -70)Have you received a pneumovax vaccine (pneumonia shot)? = No, but I am allergic or was told by my provider not to get this vaccine 617 Numerator *PDD- VACCINE PNEUMO ALLERGIC PHR200001023.3 Have you ever gotten the vaccine for pneumonia? = No, but I am allergic or was told by my provider not to get this vaccine 617 Numerator *PDD- VACCINE PNEUMO ALLERGIC ATV3446.11100 Was the reason why because you are allergic to the pneumonia vaccine? = Yes 617 Numerator *PDD- VACCINE PNEUMO ALLERGIC ATV43.70139 (Ages 2 -70)Have you received a pneumovax vaccine (pneumonia shot)? = No, but I am allergic or was told by my provider not to get this vaccine 617 Numerator *PDD- VACCINE PNEUMO ALLERGIC AA22186.82719 Have you received a pneumococcal vaccination? = No, but I am allergic or was told by my provider not to get this vaccine 617 Numerator *PDD- VACCINE PNEUMO ALLERGIC AA16000.77365 (Ages >70)Have you received a pneumovax vaccine (pneumonia shot) since turning 65 yrs old? = No, but I am allergic or was told by my provider not to get this vaccine 617 Numerator *PDD- VACCINE PNEUMO ALLERGIC AA3446.11100 Was the reason why because you are allergic to the pneumonia vaccine? = Yes 617 Numerator *PDD- VACCINE PNEUMO ALLERGIC ATV22186.82719 Have you received a pneumococcal vaccination? = No, but I am allergic or was told by my provider not to get this vaccine 617 Numerator *PDD- VACCINE PNEUMO ALLERGIC ATV16000.77365 (Ages >70)Have you received a pneumovax vaccine (pneumonia shot) since turning 65 yrs old? = No, but I am allergic or was told by my provider not to get this vaccine
Denominator	Patients who are between 5-64 years with a high risk condition (e.g., diabetes, heart failure, COPD, end-stage kidney disease, asplenia, malignancy, solid organ transplant, on immunosuppressive medications,) or patients age 65 years and older.

Denominator Details	DENOMINATOR One of the following is correct: 1. Presence of At Least 1 Refill IMMUNOSUPPRESSIVE RX 90 Total Days Supply In the past 6 Months 2. Presence of At Least 2 CANCER Diagnosis in the past 12 months 3. Presence of At Least 1 TRANSPLANT SOLID ORGAN (CPT) Procedure In the past Anytime 4. Presence of At Least 1 TRANSPLANT SOLID ORGAN (ICD9) Diagnosis in the past anytime 5. COPD validation is confirmed (see below) 6. CKD Stage 5 validation is confirmed (see below) 7. CHF Any Stage validation is confirmed (see below) 8. Diabetes adult validation is confirmed (see below) 9. Pediatric type 2 diabetes validation is confirmed (see below) 10. Pediatric type 1 diabetes validation is confirmed (see below) 11. Dialysis Chronic Validation is confirmed (see below) 12. Human Immunodeficiency Virus (HIV) validation is confirmed (see below) 13. Presence of at least 2 NEPHROTIC SYNDROME diagnosis in the past 12 months 14. All of the following are correct: a. Presence of at least 1 SPLENECTOMY INDICATIONS diagnosis anytime in the past b. Presence of at least 1 SPLENECTOMY procedure anytime in the past VALIDATION RULES COPD Validation All of the following are correct: 1. Patient age >/= 35 years 2. One of the following is correct: a. Presence of at least 1 COPD diagnosis anytime in the past from EHR data b. Presence of at least 1 COPD diagnosis anytime in the past from disability data c. All of the following are correct: i. Presence of at least 2 COPD diagnosis in the past 5 years from claims data ii. One of the following is correct: 1. Presence of at least 2 refills INHALED ANTICHOLINERGIC AND BETA-AGONIST COMBO in the past 12 months from EHR data 2. Presence of at least 2 refills INHALED ANTICHOLINERGIC AND BETA-AGONIST COMBO in the past 12 months from claims data 3. Presence of at least 2 refills BRONCHODILATOR (LONG ACTING) exists in the past 12 months from EHR data 4. Presence of at least 2 refills BRONCHODILATOR (LONG ACTING) exists in the past 12 months from claims data

	5. Presence of at least 1 COPD CPT procedure in the past 12 months 6. Presence of at least 2 refills THEOPHYLLINE in the past 12 months from EHR data 7. Presence of at least 2 refills THEOPHYLLINE in the past 12 months from claims data 8. Presence of at least 2 HOME O2 THERAPY (HCPCS) procedure in the past 12 months 9. All of the following are correct: a. One of the following is correct: i. Presence of at least 2 refills B-AGONIST (SHORT ACTING-INHALED) in the past 12 months from EHR data ii. Presence of at least 2 refills B-AGONIST (SHORT ACTING-INHALED) in the past 12 months from claims data b. One of the following is correct: i. Presence of at least 2 refills INHALED ANTICHOLINERGIC DRUGS in the past 12 months from EHR data ii. Presence of at least 2 refills INHALED ANTICHOLINERGIC DRUGS in the past 12 months from claims data d. Presence of patient data confirming at least 1 PDD- COPD in the past COPD Validation Exclusion One of the following is correct: 1. Presence of at least 1 TRANSPLANT LUNG (CPT) procedure anytime in the past 2. Presence of at least 2 TRANSPLANT LUNG (ICD-9) diagnosis anytime in the past CKD Stage 5 Validation One of the following is correct: 1. Presence of at least 1 CKD STAGE 5 diagnosis in the past 12 months from EHR data 2. Presence of at least 1 ESRD/DIALYSIS (ICD-9) diagnosis in the past 12 months from EHR data 3. Presence of at least 1 CKD STAGE 5 diagnosis in the past 12 months from disability data 4. Presence of at least 1 ESRD/DIALYSIS (ICD-9) diagnosis in the past 12 months from disability data 5. Presence of at least 2 CKD STAGE 5 diagnosis in the past 12 months at least 3 months apart from claims data 6. Presence of at least 2 ESRD/DIALYSIS (ICD-9) diagnosis in the past 12 months at least 3 months apart from claims data 7. All of the following are correct: a. Presence of at least 2 CKD - NOS diagnosis in the past 12 months at least 3 months apart from claims data b. Presence of at least 1 result for creatinine clearance between 0.1 And 14 in the past c. Patient age = 18 years 8. Presence of at least 2 DIALYSIS CHRONIC (CPT) procedure in the past 12 months 9. Presence of patient data confirming at least 1 PDD - DIALYSIS in the past 12 months

	CKD Stage 5 Validation Exclusion The following is correct: 1. Presence of at least 1 TRANSPLANT RENAL (CPT) procedure in the past 12 months CHF Any Stage Validation All of the following are correct: 1. Patient age >/= 18 years 2. One of the following is correct: a. Presence of at least 1 CHF (CONGESTIVE HEART FAILURE) diagnosis anytime in the past from EHR data b. Presence of at least 1 CHF (CONGESTIVE HEART FAILURE) diagnosis anytime in the past from disability data c. Presence of at least 1 CHF - EF <40 procedure in the past 12 months d. Presence of at least 4 CHF (CONGESTIVE HEART FAILURE) diagnosis in the past 24 months with at least a 6-month separation between claims. e. All of the following are correct: i. Presence of at least 2 CHF (CONGESTIVE HEART FAILURE) diagnosis anytime in the past from claims data 1. One of following is correct: a. Presence of at least 1 refill CARVEDILOL/LONG ACTING METOPROLOL 60 total days supply in the past 12 months b. Presence of at least 1 refill BIDIL 60 total days supply in the past 12 months c. Presence of at least 1 refill SPIRONOLACTONE/ EPLERENONE 60 total days supply in the past 12 months d. All of the following are correct: i. Presence of at least 1 refill ANTIHYPE/ ARB-ACEI 60 total days supply in the past 12 months ii. Presence of at least 1 refill DIURETICS/ LOOP DIURETICS 60 total days supply in the past 12 months e. All of the following are correct: i. Presence of at least 1 refill HYDRALAZINE 60 total days supply in the past 12 months ii. Presence of at least 1 refill NITRATES-LONG ACTING 60 total days supply in the past 12 months f. All of the following are correct: i. Presence of at least 1 refill DIGOXIN 60 total days supply in the past 12 months ii. Exclusion – Presence of at least 2 ATRIAL FIBRILLATION diagnosis in the past 12 months f. Presence of patient data confirming at least 1 PDD- EJECTION FRACTION VALUE result < 40 in the past g. Presence of patient data confirming at least 1 PDD- CHF in the past

	CHF Any Stage Validation Exclusion One of the following is correct: 1. Presence of at least 1 VALVE SURGERY procedure in the past 6 months 2. Presence of at least 1 VALVE REPLACEMENT diagnosis in the past 6 months 3. Presence of at least 1 TRANSPLANT HEART (ICD-9) diagnosis anytime in the past from EHR data 4. Presence of at least 1 TRANSPLANT HEART (ICD-9) diagnosis anytime in the past from disability data 5. Presence of at least 2 TRANSPLANT HEART (ICD-9) diagnosis anytime in the past from claims data 6. Presence of at least 1 TRANSPLANT HEART (CPT) procedure anytime in the past Diabetes Adult Validation All of the following are correct: 1. Patient age >/= 18 years 2. One of the following is correct: a. Presence of at least DIABETES MELLITUS diagnosis anytime in the past from EHR data b. Presence of at least DIABETES MELLITUS diagnosis anytime in the past from disability data c. Presence of at least 4 DIABETES MELLITUS diagnosis in the past 12 months with at least a 3 month separation between claims d. All of the following are correct: i. Presence of at least 1 DIABETES MELLITUS diagnosis in the past 5 years beginning at least 1 month in the past ii. One of the following is correct: 1. Presence of at least 2 refills DM MEDS AND SUPPLIES exists in the past 12 months from EHR data 2. Presence of at least 2 refills DM MEDS AND SUPPLIES exists in the past 12 months from claims data 3. Presence of at least 2 DM MEDS AND SUPPLIES (HCPCS) procedure in the past 12 months 4. Presence of at least 1 INSULIN THERAPY (HCPCS) procedure in the past 12 months 5. Presence of at least 1 HBA1C VALUE > 7.5 in the past 12 months e. Presence of patient data confirming at least 1 PDD- DIABETES in the past 24 months Diabetes Validation Exclusion One of the following is correct: 1. Presence of 2 DIABETES STEROID-INDUCED diagnosis in the past 12 months 2. All of the following are correct: • Presence of at least 2 GESTATIONAL DM/POLYCYSTIC OVARIES diagnosis in the past 12 months • Female gender

	Pediatric Type 1 Diabetes Validation All of the following are correct: 1. Patient age is between 2 and 18 years 2. One of the following is correct: a. All of the following are correct: i. Presence of at least 2 DIABETES TYPE 1 diagnosis in the past 5 years ii. One of the following is correct: 1. Presence of at least 2 refills DM MEDS AND SUPPLIES exists in the past 12 months 2. Presence of at least 2 DM MEDS AND SUPPLIES (HCPCS) procedure in the past 12 months 3. Presence of at least 1 refill DM MEDS/INSULIN exists in the past 6 months 4. Presence of at least 1 refill of INSULIN (ICD9) diagnosis in the past 12 months b. Presence of patient data confirming at least 1 PDD- DM TYPE 1 (PEDS) in the past Pediatric Type 1 Diabetes Validation Exclusion One of the following is correct: 1. Presence of at least 1 GESTATIONAL DM diagnosis in the past 12 months 2. Presence of at least 1 TRANSPLANT PANCREAS (CPT) procedure anytime in the past Pediatric Type 2 Diabetes Validation All of the following are correct: 1. Patient age is between 2 and 18 years 2. One of the following is correct: a. All of the following are correct: i. Presence of at least 2 DIABETES TYPE 2 diagnosis in the past 5 years ii. One of the following is correct: 1. Presence of at least 2 refills DM MEDS AND SUPPLIES in the past 12 months 2. Presence of at least 2 DM MEDS AND SUPPLIES (HCPCS) procedure in the past 12 months iii. Exclusion - Presence of at least 1 DIABETES TYPE 1 diagnosis in the past 5 years b. All of the following are correct: i. Presence of at least 1 DIABETES TYPE 1 diagnosis in the past 5 years ii. Presence of at least 1 DIABETES TYPE 2 diagnosis in the past 5 years iii. Presence of at least 1 refill DM MEDS/ORAL AGENTS exists in the past 6 months iv. Exclusion – if one of the following is correct: 1. Presence of at least 1 refill DM MEDS/INSULIN exists in the past 6 months 2. Presence of at least 1 INSULIN THERAPY (HCPCS) procedure in the past 6 months 3. Presence of at least 1 INSULIN THERAPY (ICD9) procedure in the past 6 months c. Presence of patient data confirming at least 1 PDD- DM TYPE 2 (PEDS) in the past

	Pediatric Type 2 Diabetes Validation Exclusion One of the following is correct: 1. Presence of at least 1 GESTATIONAL DM diagnosis in the past 12 months 2. Presence of at least 1 TRANSPLANT PANCREAS (CPT) procedure anytime in the past Dialysis Chronic Validation One of the Following Expressions is correct: 1. Presence of at least 1 DIALYSIS (ICD9) diagnosis in the past 12 months from EHR data 2. Presence of at least 1 DIALYSIS (ICD9) diagnosis in the past 12 months from disability data 3. Presence of at least 2 DIALYSIS CHRONIC (CPT) procedure in the past 12 Months Timeframe Between Claims No Timeframe Begins on CE Run Date 4. Presence of patient data confirming at least 1 PDD- DIALYSIS Result Exists 0 In the past 12 Months Timeframe Dialysis Chronic Validation Exclusion The following is correct: 1. Presence of at least 1 TRANSPLANT RENAL (CPT) Procedure in the past 12 months HIV Validation One of the following is correct: 1. Presence of at least 1 HIV diagnosis anytime in the past from EHR data 2. Presence of at least 1 HIV diagnosis anytime in the past from disability data 3. Presence of At Least 4 HIV diagnosis in the past 24 months with at least one 3 month separation between claims 4. All of the following are correct: a. Presence of at least 2 HIV diagnosis in the past 24 Months from claims data b. One of the following is correct: i. Presence of at least 2 refill ANTIRETROVIRAL AGENTS/ALL in the past 12 Months from EHR data ii. Presence of at least 2 refills ANTIRETROVIRAL AGENTS/ALL in the past 12 Months iii. Presence of at least 1 VIRAL LOAD procedure in the past 12 months iv. Presence of at least 1 CD4 procedure in the past 12 months v. Presence of at least 1 VIRAL LOAD MONITORING labs result in the past 12 months vi. Presence of at least 1 CD4 COUNT MONITORING labs result in the past 12 months 5. Presence of patient data confirming at least 1 PDD- HIV result anytime in the past Note: A 3-month time window has been added to certain timeframes to account for the inherent delay in the acquisition of administrative claims data. Note: A current refill is defined as a refill in which the total day supply of a drug plus a grace period of an additional 30 days extends into the end of the measurement window. See attached for code set

Exclusions	General exclusions: - Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months; - Patients who have been in a skilled nursing facility in the last 3 months
Exclusion details	
Risk Adjustment	No risk adjustment or risk stratification
Stratification	This measure is not stratified.
Numerator Time window	1. Anytime in the past. 2. Anytime in the past
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry, Other
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Health Plan, Integrated Delivery System, Population : Community, Population : County or City, Population : National, Population : Regional, Population : State
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Dialysis Facility, Home Health, Hospital/Acute Care Facility, Laboratory, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation

	Measure 0629: Male Smokers or Family History of Abdominal Aortic Aneurysm (AAA) - Consider Screening for AAA (ActiveHealth Management)
Description	The percentage of men age 65-75 years with history of tobacco use or men age 60 yrs and older with a family history of abdominal aortic aneurysm who were screened for AAA
Numerator	Men who have had AAA screening.
Numerator Details	1. The Denominator is true 2. One of the following is correct: a. Presence of Patient Data Confirming at least 1 PDD-Screening for AAA OBSER in the past b. Presence of at least 1 AAA Repair Procedure in the past c. Presence of at least 1 Abdominal Aortic Aneurysm Diagnosis in the past d. Presence of At Least 1 Abdominal Imaging Procedure in the past Note: A 3 month time window has been added to certain timeframes in order to account for the inherent delay in the acquisition of administrative claims data. 629 Numerator *AAA REPAIR 34800 EVASC RPR AAA W/AORTO-AORTIC TUBE PROSTH 629 Numerator *AAA REPAIR 34825 PLMT XTN PROSTH EVASC RPR ARYSM/DSJ 1ST VSL 629 Numerator *ABDOMINAL IMAGING 74175 CT ANGIOGRAPHY ABDOMEN W/CONTRAST/NONCONTRAST(Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing) 629 Numerator *ABDOMINAL IMAGING 76770 US RETROPERITONEAL R-T W/IMAGE COMPL (Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete) 629 Numerator *PDD- SCREENED FOR AAA AA12872.47601 Male smokers 65-75 y/o only are at risk for abdominal aortic aneurysm (AAA). Have you been screened w/ abdominal ultrasound? = Yes 629 Numerator *AAA REPAIR 0002T -01 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; aorto-uni-iliac or ao 629 Numerator *AAA REPAIR 0080T EVASC RPR AAA PSEUDOARYSM ABDL AORTA VISC RS&I 629 Numerator *AAA REPAIR 0081T PLMT VISC XTN PROSTH EVASC RPR AAA EA VISC RS&I 629 Numerator *ABDOMINAL AORTIC ANEURYSM 441.5 AORTIC ANEURYSM OF UNSPECIFIED SITE RUPTURED 629 Numerator *ABDOMINAL IMAGING 74181 MRI ABD C-MATRL(Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)) 629 Numerator *ABDOMINAL IMAGING 75635 CTA AA&BI ILIOFEM LXTR RS&I C-/C+ POST-PXESSING(Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing) 629 Numerator *ABDOMINAL IMAGING 76775 US RPR B-SCAN&/R-T IMG LMTD (Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited) 629 Numerator *ABDOMINAL IMAGING C8902 MR ANGIO WITHOUT CONTRST FOLLOWED W/CONTRST ABD(Magnetic resonance angiography without contrast followed by with contrast, abdomen) 629 Numerator *ABDOMINAL IMAGING 88.47 ARTERIOGRAPHY OF OTHER INTRA-ABDOMINAL ARTERIES (Arteriography of other intra-abdominal arteries) 629 Numerator *PDD- SCREENED FOR AAA HMT275.1 Have you been screened for or received treatment for abdominal aortic aneurysm (AAA)? = Yes 629 Numerator *AAA REPAIR 34803 EVASC RPR AAA W/MDLR BFRC PROSTH 2 LIMBS 629 Numerator *AAA REPAIR 34830 OPN RPR ARYSM RPR ARTL TRAUMA TUBE PROSTH 629 Numerator *AAA REPAIR 34831 OPN RPR ARYSM RPR ARTL TRMA AORTOBIILIAC PROSTH

	629 Numerator *AAA REPAIR 35103 DIR RPR ARYSM&GRF RPTD ARYSM ABDL AORTA ILIAC 629 Numerator *AAA REPAIR 35331 TEAEC +-PATCH GRF ABDL AORTA 629 Numerator *ABDOMINAL AORTIC ANEURYSM 441.1 THORACIC ANEURYSM, RUPTURED 629 Numerator *ABDOMINAL IMAGING 74150 CT ABD C-MATRL (Computed tomography, abdomen; without contrast material 629 Numerator *ABDOMINAL IMAGING 74183 MRI ABD C-/C+(Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequence) 629 Numerator *ABDOMINAL IMAGING 74185 MRA ABD C+-MATRL(Magnetic resonance angiography, abdomen, with or without contrast material(s)) 629 Numerator *ABDOMINAL IMAGING 75600 AORTOGRAPY THRC W/O SRLOGRAPY RS&I(Aortography, thoracic, without serialography, radiological supervision and interpretation) 629 Numerator *ABDOMINAL IMAGING 76700 US ABDOMINAL R-T W/IMAGE DOCUMENTATION (Ultrasound, Complete abdominal, real time with image documentation) 629 Numerator *ABDOMINAL IMAGING 88.76 DIAGNOSTIC ULTRASOUND OF ABDOMEN&RETROPERITONEUM (Magnetic resonance angiography, abdomen, with or without contrast material(s)) 629 Numerator *PDD- SCREENED FOR AAA PHR200001013.1 Have you ever been screened for an enlarged artery in your stomach area called an aortic aneurysm? = Yes 629 Numerator *AAA REPAIR 34826 PLMT XTN PROSTH EVASC RPR ARYSM/DSJ EA VSL 629 Numerator *AAA REPAIR 35102 DIR RPR ARYSM&GRF INSJ ABDL AORTA ILIAC VSL 629 Numerator *AAA REPAIR M0301 FABRIC WRAPPING OF ABDOMINAL ANEURYSM 629 Numerator *AAA REPAIR 0079T PLMT VISC XTN PROSTH EVASC RPR AAA EA VISC 629 Numerator *ABDOMINAL AORTIC ANEURYSM 441. AORTIC ANEURYSM* 629 Numerator *ABDOMINAL AORTIC ANEURYSM 441.7 THORACOABD ANEURYSM WITHOUT MENTION RUPTURE 629 Numerator *ABDOMINAL AORTIC ANEURYSM 447.73 THORACOABDOMINAL AORTIC ECTASIA 629 Numerator *ABDOMINAL IMAGING 74170 CT ABD C-/C+(Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections) 629 Numerator *ABDOMINAL IMAGING 75605 AORTOGRAPY THRC SRLOGRAPY RS&I(Aortography, thoracic, by serialography, radiological supervision and interpretation) 629 Numerator *ABDOMINAL IMAGING 88.01 COMPUTERIZED AXIAL TOMOGRAPHY OF ABDOMEN(Computerized axial tomography of abdomen) 629 Numerator *AAA REPAIR 34804 EVASC RPR AAA W/UNIBDY BFRC PROSTH 629 Numerator *AAA REPAIR 34832 OPN RPR ARYSM RPR ARTL TRMA AORTO-BIFEM PROSTH 629 Numerator *AAA REPAIR 35092 DIR RPR ARYSM&GRF RPTD ARYSM ABDL AORTA VISC VSL 629 Numerator *AAA REPAIR 0078T EVASC RPR AAA PSEUDOARYSM ABDL AORTA VISC 629 Numerator *AAA REPAIR 33877 RPR THORACOAAA W/GRF +-CARD BYP 629 Numerator *ABDOMINAL AORTIC ANEURYSM 441.03 DISSECTING AORTIC ANEURYSM THORACOABDOMINAL 629 Numerator *ABDOMINAL AORTIC ANEURYSM 441.9 AORTIC ANEUR UNSPEC SITE WITHOUT MENTION RUPTURE 629 Numerator *ABDOMINAL AORTIC ANEURYSM 447.72 ABDOMINAL AORTIC ECTASIA 629 Numerator *ABDOMINAL IMAGING 74182 MRI ABD C+ MATRL(Magnetic resonance angiography without contrast, abdomen) 629 Numerator *ABDOMINAL IMAGING C8901 MR ANGIOGRAPHY WITHOUT CONTRAST ABDOMEN (Magnetic resonance angiography without contrast, abdomen)

	629 Numerator *ABDOMINAL IMAGING 74177 CT ABD & PELVIS W/CONTRAST (Computed tomography, abdomen and pelvis; with contrast material(s)) 629 Numerator *ABDOMINAL IMAGING 74178 CT ABD & PELVIS W/O CONTRST 1+ BODY REGNS (Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions) 629 Numerator *PDD- SCREENED FOR AAA AA14857.55826 MALES OVER 60 ONLY: Have you ever been screened for AAA? = Yes 629 Numerator *AAA REPAIR 0001T ENDOVSC REP INFRARENL AAA MODULR BIFURCAT PROSTH 629 Numerator *AAA REPAIR 34802 EVASC RPR AAA W/MDLR BFRC PROSTH 1 LIMB 629 Numerator *AAA REPAIR 34833 ILIAC ART EXPOS W/CRTJ CONDUIT UNI 629 Numerator *AAA REPAIR 34834 BRACH ART EXPOS DPLMNT AORTIC/ILIAC PROSTH UNI 629 Numerator *AAA REPAIR 75953 PLMT XTN PROSTH EVASC RPR INFRARNL RS&I 629 Numerator *ABDOMINAL AORTIC ANEURYSM 441.02 DISSECTING AORTIC ANEURYSM ABDOMINAL 629 Numerator *ABDOMINAL IMAGING 74160 CT ABD C+ MATRL (Computed tomography, abdomen; with contrast material(s)) 629 Numerator *ABDOMINAL IMAGING G0389 US B-SCAN &/OR REAL TIME W/IMAG DOC; AAA SCREEN(Ultrasound B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening) 629 Numerator *ABDOMINAL IMAGING 74176 CT ABD & PELVIS W/O CONTRAST (Computed tomography, abdomen and pelvis; without contrast material) 629 Numerator *PDD- SCREENED FOR AAA ATV12872.47601 Male smokers 65-75 y/o only are at risk for abdominal aortic aneurysm (AAA). Have you been screened w/ abdominal ultrasound? = Yes 629 Numerator *AAA REPAIR 34805 EVASC RPR AAA AORTO-UNIILIAC/AORTO-UNIFEM PROSTH 629 Numerator *AAA REPAIR 35081 DIR RPR ARYSM&GRF INSJ ABDL AORTA 629 Numerator *AAA REPAIR 35082 DIR RPR ARYSM&GRF INSJ RPTD ARYSM ABDL AORTA 629 Numerator *ABDOMINAL AORTIC ANEURYSM 441.4 ABDOMINAL ANEURYSM WITHOUT MENTION OF RUPTURE 629 Numerator *ABDOMINAL AORTIC ANEURYSM 441 AORTIC ANEURYSM AND DISSECTION 629 Numerator *ABDOMINAL IMAGING 75630 AORTOGRAPY ABDL BI ILIOFEM LXTR CATH RS&I (Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation)
Denominator	Men age 65-75 years with a history of tobacco use (current or ever) or Men age 60 and older with a family history of abdominal aortic aneurysm based on patient derived data or claims data Time Window: Anytime in the past

Denominator Details	One of the following: A. All of the following expressions are correct: 1. Patient age >= 60 years and patient gender male 2. Presence of patient data confirming at least 1 PDD- FHx AAA in the past 12 months B. All of the following expressions are correct: 1. Patient Age between 65-75 Years and patient gender male 2. One of the following is correct: a. Presence of at least 2 Smoking-Current and Past diagnosis in the past b. Presence of at least 1 Smoking Cessation Procedure in the past c. Presence of at least 1 Refill Smoking Cessation drug in the past d. Presence of Patient Data Confirming at least 1 PDD-Smoker (past and current) in the past One of the following: A. All of the following expressions are correct: 1. Patient age >= 60 years and patient gender male 2. Presence of patient data confirming at least 1 PDD- FHx AAA in the past 12 months B. All of the following expressions are correct: 1. Patient Age between 65-75 Years and patient gender male 2. One of the following is correct: a. Presence of at least 2 Smoking-Current and Past diagnosis in the past b. Presence of at least 1 Smoking Cessation Procedure in the past c. Presence of at least 1 Refill Smoking Cessation drug in the past d. Presence of Patient Data Confirming at least 1 PDD-Smoker (past and current) in the past
Exclusions	There are no specific exclusions to this measure. General exclusions: • Evidence of metastatic disease or active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months; • Patients who have been in a skilled nursing facility in the last 3 months
Exclusion details	See above.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	See above.
Numerator Time window	Time Window: One time in the past
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry, Patient Reported Data/Survey
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Health Plan, Integrated Delivery System, Population : Community, Population : County or City, Population : National, Population : Regional, Population : State
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

	Measure 0033: Chlamydia screening in women (National Committee for Quality Assurance)
Description	Assesses the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
Numerator	At least one chlamydia test during the measurement year as documented through administrative data.
Numerator Details	At least one chlamydia test during the measurement year. Administrative Specification: One or more of the following codes to identify Chlamyida Screening CPT: 87110, 87270, 87320, 87490-87492 87810 LOINC: 557-9, 560-3, 4993-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 50387-0, 53925-4, 53926-2
Denominator	Women 16–24 years.
Denominator Details	Women 16–24 years as of December 31 of the measurement year who are sexually active. Continuous enrollment: The measurement year. Allowable gap: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). Anchor date: December 31 of the measurement year. Benefit: Medical. Sexually active. Three methods identify sexually active women: pharmacy data, claim/encounter data and medical records data. The organization must use all methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure. As documented in the specifications, there are two methods for identifying sexually active women using administrative data: pharmacy data and claim/encounter data. The organization must use both methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure. Pharmacy data. Members who were dispensed prescription contraceptives during the measurement year (the measure provides a list of prescriptions). Claim/encounter data. Members who had at least one encounter during the measurement year with any code in the table of CPT, HCPCS, ICD-9-CM Diagnosis, ICD-9-CM Procedure or UB Revenue codes provided in the measure For Electronic and Hybrid Specifications, use the first two methods to identify the eligible population, although a patient must appear in only one method to be eligible for the measure. For Medical Record Specifications, use the third method. Table CHL-A: Prescriptions to Identify Contraceptives: desogestrel-ethinyl estradiol; drospirenone-ethinyl estradiol; estradiol-medroxyprogesterone; ethinyl estradiol-ethynodiol; ethinyl estradiol-etonogestrel; ethinyl estradiol-levonorgestrel; ethinyl estradiol-norelgestromin; ethinyl estradiol-norethindrone; ethinyl estradiol-norgestimate; ethinyl estradiol-norgestrel; etonogestrel; levonorgestrel; medroxyprogesterone; mestranol-norethindrone; norethindrone Diaphragm: diaphragm Spermicide: nonxynol 9

	Table CHL-B: Codes to Identify Sexually Active Women CPT: 11975-11977, 57022, 57170, 58300, 58301, 58600, 58605, 58611, 58615, 58970, 58974, 58976, 59000, 59001, 59012, 59015, 59020, 59025, 59030, 59050, 59051, 59070, 59072, 59074, 59076, 59100, 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151, 59160, 59200, 59300, 59320, 59325, 59350, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622, 59812, 59820, 59821, 59830, 59840, 59841, 59850-59852, 59855-59857, 59866, 59870, 59871, 59897, 59898, 59899, 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 76941, 76945-76946, 80055, 81025, 82105, 82106, 82143, 82731, 83632, 83661-83664, 84163, 84702-84704, 86592, 86593, 86631-86632, 87110, 87164, 87166, 87270, 87320, 87490-87492, 87590-87592, 87620-87622, 87660, 87808, 87810, 87850, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175, 88235, 88267, 88269 HCPCS: G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, H1000, H1001, H1003-H1005, P3000, P3001, Q0091, S0199, S4981, S8055 ICD-9-CM Diagnosis: 042, 054.10, 054.11, 054.12, 054.19, 078.11, 078.88, 079.4, 079.51-079.53, 079.88, 079.98, 091-097, 098.0, 098.10, 098.11, 098.15-098.19, 098.2, 098.30, 098.31, 098.35-098.8, 099, 131, 339.82, 614, 615, 622.3, 623.4, 626.7, 628, 630-679, 795.0, 795.1, 796.7, 996.32, V01.6, V02.7, V02.8, V08, V15.7, V22-V28, V45.5, V61.5-V61.7, V69.2, V72.3, V72.4, V73.81, V73.88, V73.98, V74.5, V76.2 ICD-9-CM Procedure: 69.01, 69.02, 69.51, 69.52, 69.7, 72-75, 88.78, 97.24, 97.71, 97.73 UB Revenue: 0112, 0122, 0132, 0142, 0152, 0720-0722, 0724, 0729, 0923, 0925 Table CHL-B: Codes to Identify Sexually Active Women (continued) LOINC: 557-9, 560-3, 660-1, 688-2, 690-8, 691-6, 692-4, 693-2, 698-1, 1832-5, 1834-1, 2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9, 2114-7, 2115-4, 2118-8, 2119-6, 4993-2, 5028-6, 5291-0, 5292-8, 5392-6, 5393-4, 5394-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 6487-3, 6488-1, 6489-9, 6510-2, 6511-0, 6514-4, 6516-9, 6561-5, 6562-3, 7975-6, 8041-6, 10524-7, 10705-2, 11083-3, 11084-1, 11481-9, 11597-2, 12222-6, 12223-4, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14499-8, 14500-3, 14502-9, 14503-7, 14504-5, 14506-0, 14509-4, 14510-2, 14513-6, 15019-3, 16280-0, 16600-9, 16601-7, 17398-9, 17399-7, 17400-3, 17401-1, 17402-9, 17403-7, 17404-5, 17405-2, 17406-0, 17407-8, 17408-6, 17409-4, 17410-2, 17411-0, 17412-8, 17723-8, 17724-6, 17725-3, 17726-1, 17727-9, 17728-7, 17729-5, 18500-9, 19080-1, 19171-8, 19176-7, 19177-5, 19180-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 20403-2, 20404-0, 20415-6, 20507-0, 20508-8, 20994-0, 21189-6, 21190-4, 21191-2, 21192-0, 21198-7, 21414-8, 21415-5, 21416-3, 21440-3, 21441-1, 21613-5, 22461-8, 22462-6, 22587-0, 22590-4, 22592-0, 22594-6, 23838-6, 24110-9, 24111-7, 24312-1, 25372-4, 25373-2, 26009-1, 29311-8, 30167-1, 31147-2, 31771-9, 31772-7, 31775-0, 31777-6, 31905-3, 31906-1, 31993-9, 32198-4, 32199-2, 32705-6, 33717-0, 33773-3, 34147-9, 34382-2, 34493-7, 34656-9, 34670-0, 34718-7, 35457-1, 36902-5, 36903-3, 38372-9, 40679-3, 40680-1, 41273-4, 41274-2, 42316-0, 42481-2, 42931-6, 43304-5, 43305-2, 43403-5, 43404-3, 43406-8, 43798-8, 44543-7, 44544-5, 44546-0, 44547-8, 44549-4, 44550-2, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 45327-4, 45331-6, 45332-4, 46731-6, 46989-0, 47211-8, 47212-6, 47236-5, 47237-3, 47238-1, 47387-6, 47527-7, 47528-5, 48030-1, 48039-2, 48560-7, 48781-9, 49096-1, 49246-2, 49318-9, 49891-5, 49896-4, 50387-0, 50388-8, 50690-7, 51838-1, 51839-9, 53605-2, 53762-1, 53879-3, 53925-4, 53926-2, 53927-0, 55299-2, 55869-2, 55870-0, 56497-1, 57032-5

	Medical record data Documentation of contraceptive use (prescription or other), any diagnosis or procedure listed below (and in Table CHL-B) or any relevant documentation of marital or intimate partner status in the medical record. • Pregnancy test • Alpha-fetoprotein (AFP) test • Fibrinonectin test • Syphilis test • Chlamydia trachomatis test • Chlamydia species test • Neiserria gonorrhoeae test • Chlamydia trachomatis and neiserria gonorrhoeae test • Human papillomavirus (HPV) test • Pap test • Amniotic fluid cytogenetics test • Obstetric panel
Exclusions	Members who had a pregnancy test during the measurement year, followed within seven days (inclusive) by either a prescription for isotretinoin (Accutane) or an x-ray. This exclusion does not apply to members who qualify for the denominator based on services other than the pregnancy test alone. Refer to Table CHL-D and Table CHL-E to identify exclusions.
Exclusion details	Codes to Identify Exclusions Pregnancy test - CPT: 81025, 84702, 84703; UB Revenue: 0925; LOINC: 2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9, 2114-7, 2115-4, 2118-8, 2119-6, 19080-1, 19180-9, 20415-6, 20994-0, 21198-7, 25372-4, 25373-2, 34670-0, 55869-2, 55870-0, 56497-1 WITH Diagnostic radiology – CPT: 70010-76499; UB Revenue: 032x Table CHL-E: Medications to Identify Exclusions Description: Retinoid Prescription: isotretinoin
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Two age stratifications and a total rate are reported. • 16–20 years • 21–24 years • Total (sum of the two age stratifications)
Numerator Time window	December 31 of the measurement year.
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy
Level	Clinician : Group/Practice, Clinician : Individual, Health Plan
Setting	Ambulatory Care : Clinician Office

	Measure 0037: Osteoporosis testing in older women (National Committee for Quality Assurance)
Description	Percentage of female patients aged 65 and older who reported receiving a bone density test (BMD) to check for osteoporosis
Numerator	The number of patients in the denominator who responded “yes” to the question, “Have you ever had a bone density test to check for osteoporosis, sometimes thought of as “brittle bones”? This test may have been done to your back, hip, wrist, heel, or finger.”
Numerator Details	Reponses of “yes” to Q52 in the Medicare Health Outcomes Survey (HOS) "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as "brittle bone´s"? This test may have been done to your back, hip, wrist, heel or finger.”
Denominator	Women 65 and older as of December 31 of the measurement year who answered “yes” or “no” to the question, “Have you ever had a bone density test to check for osteoporosis, sometimes thought of as “brittle bones”? This test may have been done to your back, hip, wrist, heel, or finger.”
Denominator Details	Female Medicare members age 65 and above
Exclusions	
Exclusion details	
Risk Adjustment	No risk adjustment or risk stratification
Stratification	
Numerator Time window	Measurement year (one calendar year)
Type	Process
Type of Score	Rate/proportion
Data Source	Patient Reported Data/Survey
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Health Plan, Integrated Delivery System, Population : National
Setting	Ambulatory Care : Clinician Office

	Measure 1653: Pneumococcal Immunization (PPV 23) (Centers for Medicare and Medicaid Services)
Description	Inpatients age 65 years and older and 6-64 years of age who have a high risk condition who are screened for 23-valent Pneumococcal Polysaccharide Vaccine (PPV23)status and vaccinated prior to discharge if indicated.
Numerator	Inpatient discharges who were screened for PPV23 status and received PPV23 prior to discharge if indicated.
Numerator Details	The following patients are included in the numerator; Patients who received PPV23 during this hospitalization, Patients who receive PPV23 anytime in the past, Patients who were offered and declined the PPV during this hospitalization and Patients who have an allergy/sensitivity to the vaccine or the vaccine is not likely to be effective due to the following; hypersensitivity to componant(s) of the vaccine, bone marrow transplants within the past 12 months, receipt of chemotherapy or radiation during this hospitalization or less thn 2 weeks prior to this hospitalization or received the shingles vaccine (Zostavax) within the last 4 weeks prior to this hospitalization.
Denominator	Inpatient discharges 65 years of age and older and 6-64 years of age who have a high risk condition.
Denominator Details	All patients 65 years of age and older and 6-64 years of age who have a high risk condition (diabetes, nephric syndrome, ESRD, CHF, COPD, HIV or asplenia, see below for codes) are included in the denominator except the following; patients less thn 6 years of age, patients who expire prior to hospital discharge, patients who are pregnant and patients with an organ transplant during the current hospitalization. See attachments of the ICD-9 and ICD-10 tables for the high risk conditions. The following data elements are needed for the denominator; Admission Date, Birthdate, Discharge Disposition, ICD-9-CM Other Diagnosis Codes, ICD-9-CM Principal Diagnosis Codes (or ICD-10-CM Principal or Other depending)
Exclusions	Excluded patients consist of the following; Patients who expire prior to hospital discharge, patients with an organ transplant during the current hospitalization and pregnant women. See attachments of the ICD-9 and ICD-10 tables for transplants and pregnancy.
Exclusion details	Excluded patients consist of the following; Patients who expire prior to hospital discharge and patients with an organ transplant during the current hospitalization. See attachments of the ICD-9 and ICD-10 tables for Transplants.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	IMM-1 is stratified into the following; IMM-1a (overall rate) Pneumococcal Immunization (PPV23)) for Patients 65 years of age and older, and 6-64 years of age who have a high risk condition. IMM-1b Pneumococcal Immunization (PPV23) 65 years of age and older IMM-1c Pneumococcal Immunization (PPV23) 6-64 years of age who have a high risk condition Each of these strata are further stratified via the allowable values which are as follows; 1. Patients who received PPV23 during this hospitalization = PASS 2. Patients who receive PPV23 anytime in the past = PASS 3. Patients who were offered and declined the PPV during this hospitalization = PASS 4. Patients who have an allergy/sensitivity to the vaccine or the vaccine is not likely to be effective due to the following; hypersensitivity to componant(s) of the vaccine, bone marrow transplants within the past 12 months, receipt of chemotherapy or radiation during this hospitalization or less thn 2 weeks prior to this hospitalization or received the shingles vaccine (Zostavax) within the last 4 weeks prior to this hospitalization. = PASS 5. None of the above/Not documented/UTD = FAILURE

Numerator Time window	The time period included in this measure is the arrival time through discharge from the hospital during the same stay.
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Paper Records
Level	Facility, Population : National, Population : Regional, Population : State
Setting	Hospital/Acute Care Facility

	Measure 1659: Influenza Immunization (Centers for Medicare and Medicaid Services)
Description	Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.
Numerator	Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated.
Numerator Details	The following patients are included in the numerator; Patients who received influenza vaccine during this hospitalization, Patients who received influenza vaccine during the current year´s flu season but prior to the current hospital, Patients who were offered and declined the influenza vaccine during this hospitalization and Patients who have an allergy/sensitivity to the vaccine or the vaccine is not likely to be effective due to the following; hypersensitivity to eggs or other componant(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, bone marrow transplants within the past 6 months, anaphalactic latex allergy. The data elements needed for the numerator are: Influenza Vaccination Status ICD-9-CM Other Procedure Code ICD-9-CM Principal Procedure Code
Denominator	Inpatients age 6 months and older discharged during the months on October, November, December, January, February or March.
Denominator Details	All inpatients 6 months of age and older, discharged in October, November, December, January, February or March with the exception of the following; Patients who expire prior to hospital discharge and patients who have an organ transplant during the current hospitalization. See the 2a1.9 for ICD-9 and ICD-10 tables for transplants. The following data elements are needed for the denominator; Admission Date, Birthdate, Discharge Date, Discharge Disposition, ICD-9-CM Other Diagnosis Codes, ICD-9-CM Principal Diagnosis Codes (or ICD-10-CM Principal or Other depending)
Exclusions	Excluded patients consist of the following; Patients who expire prior to hospital discharge and patients with an organ transplant during the current hospitalization. See the 2a1.9 for ICD-9 and ICD-10 tables for transplants.
Exclusion details	Excluded patients consist of the following; Patients who expire prior to hospital discharge and patients with an organ transplant during the current hospitalization. The attached ICD-9 and ICD-10 tables for transplants.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	The allowable values are the stratification and are as follows; 1. Patients who received influenza vaccine during this hospitalization = PASS 2. Patients who receive influenza vaccine during the current year´s flu season but prior to this hospitalization = PASS 3. Patients who were offered and declined the influenza vaccine during this hospitalization = PASS 4. Patients who have an allergy/sensitivity to the vaccine or the vaccine is not likely to be effective due to the following; hypersensitivity to eggs or other componant(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, bone marrow transplants within the past 6 months or anaphylactic latex allergy = PASS 5. None of the above/Not documented/UTD = FAILURE

Numerator Time window	The time period included in this measure is the arrival time to the hospital for inpatients through discharge from the hospital during the same stay. This measure is only used during the seasonal influenza season, October-March, defined by the Centers for Disease Control and Prevention (CDC) in the MMWR Early Release, July 29th, 2010/Volume 59.
Type	Process
Type of Score	Rate/proportion
Data Source	Administrative claims, Paper Records
Level	Facility, Population : National, Population : Regional, Population : State
Setting	Hospital/Acute Care Facility

APPENDIX B: PROJECT STEERING COMMITTEE AND NQF STAFF

STEERING COMMITTEE

Paul Jarris, MD, MBA (Co-Chair)
Association of State and Territorial Health Officials
Arlington, VA

Kurt Stange, MD, PhD (Co-Chair)
Case Western Reserve University
Cleveland, OH

Ron Bialek, MPP, CQIA
Public Health Foundation
Washington, DC

Larry Cohen, MSW
Prevention Institute
Oakland, CA

Linda Kinsinger, MD, MPH
National Center for Health Promotion and Disease Prevention
Durham, NC

Sarah Linde-Feucht, MD
Health Resources and Services Administration
Rockville, MD

Keith Mason, MS
American Heart Association
Washington, DC

Rhonda Medows, MD
UnitedHealthcare
Washington, DC

Jacqueline Merrill, RN, MPH, DNSc
Columbia University
New York, NY

Madeline Naegle, PhD, FAAN, APRN, BC
New York University College of Nursing
New York, NY

Robert Pestronk, MPH
National Association of County and City Health Officials
Washington, DC

Sue Pickens, MEd
Parkland Health & Hospital System
Dallas, TX

Mary Pittman, DrPH
The Public Health Institute
Oakland, CA

Amir Qaseem, MD, PhD, MHA, FACP
American College of Physicians
Philadelphia, PA

Sarah Sampsel, MPH
WellPoint
Rio Rancho, NM

Jason Spangler, MD, MPH
Partnership for Prevention
Washington, DC

Matt Stiefel, MPA
Kaiser Permanente
Oakland, CA

Michael Stoto, PhD
Georgetown University
Washington, DC

Andrew Webber
National Business Coalition on Health
Washington, DC

NQF STAFF

Helen Burstin, MD, MPH
Senior Vice President
Performance Measures

Heidi Bossley, MSN, MBA
Vice President
Performance Measures

Robyn Y Nishimi, PhD
Consultant

Reva Winkler, MD, MPH
Senior Director
Performance Measures

Elisa Munthali, MPH
Senior Project Manager
Performance Measures

Kristin V. Chandler, MPH
Project Analyst
Performance Measures

APPENDIX C: RELATED AND COMPETING MEASURES

Side-by-Side Comparison: Specifications for Osteoporosis Measures

	0037: OLDER WOMEN: SCREENING-SURVEY (NCQA)	0046: OLDER WOMEN: SCREENING-CLAIMS/MEDICAL RECORDS (NCQA)
NUMERATOR	The number of patients in the denominator who responded "yes" to the question, "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as "brittle bones"? This test may have been done to your back, hip, wrist, heel, or finger."	Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months
DENOMINATOR	Women 65 and older as of December 31 of the measurement year who answered "yes" or "no" to the question, "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as "brittle bones"? This test may have been done to your back, hip, wrist, heel, or finger."	All female patients aged 65 years and older.
EXCLUSIONS	None	Except patients for whom central DXA measurement was not ordered or performed and pharmacologic therapy was not prescribed by reason of appropriate denominator exception, including: Documentation of medical reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy Documentation of patient reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy Documentation of system reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy
COMMENTS	During the September 2011 in-person meeting, there was considerable discussion about this measure and others currently in the Health Outcomes Survey, and possible withdrawal from inclusion in the survey.	

Side-by-Side Comparison: Specifications for Influenza Vaccination Measures

	STANDARD	1659: INPATIENT (CMS)
NUMERATOR	Number of persons specified in the denominator who • received the influenza vaccine: documented administration by the provider or patient (or responsible party/legal guardian) reported receipt from another provider (computed and reported separately) OR • were assessed and offered but declined the vaccination (computed and reported separately) OR • were assessed and determined to have medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barré syndrome within 6 weeks after a previous influenza vaccination, bone marrow transplant within the past 6 months (<6 months prior to encounters between October 1 and March 31) (computed and reported separately during the time from October 1 (or when the vaccine became available) through March 31.	Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated. *The following patients are included in the numerator: Patients who received influenza vaccine during this hospitalization; Patients who received influenza vaccine during the current year´s flu season but prior to the current hospital; Patients who were offered and declined the influenza vaccine during this hospitalization; and Patients who have an allergy/sensitivity to the vaccine or the vaccine is not likely to be effective due to the following: hypersensitivity to eggs or other componant(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, bone marrow transplants within the past 6 months, anaphalactic [sic] latex allergy. *Extracted from the numerator details.
DENOMINATOR	Number of persons • in a facility, agency, or practice with an encounter (or in a defined population) between October 1 and March 31 (OR for health plan measures, enrolled [must be defined] with a plan between October 1 and March 31) • who is age 50 and older or 6 months to 18 years OR • resides in a long-term care facility (including nursing homes and skilled nursing facilities) OR • is age 19-49 with prevalent high-risk conditions of pregnancy, diabetes, end-stage renal disease (ESRD), congestive heart failure (CHF), asthma, chronic obstructive pulmonary disease (COPD), human immunodeficiency virus (HIV). (These conditions should be included in a comprehensive measure, but are not intended to prevent focusing on a specific condition.	Inpatients 6 months and older who were discharged during October, November, December, January, February, on [sic] March.

EXCLUSIONS	Hospital patients who died before discharge.	Patients who expire prior to hospital discharge and patients with an organ transplant during the current hospitalization.
COMMENTS		1. **Difference from standard:** The numerator statement should move the details of the included population up front. The numerator should be expressed in terms of the patient, not discharge status. 2. **Difference from standard:** Timeframe allows only Oct-March and does not account for "when vaccine became available" *3.* **Difference from standard:** Are the stratification details intended to be the numerator categories specified in the standard specifications? Will they be computed and reported separately as indicated in the standard specifications? *(Also asked by the Committee in the accompanying memo.)* 4. **Difference from standard:** Is latex anaphylaxis OK to lump in with Guillain-Barre etc? All are medical contraindications – to what degree are all of them enumerated in the various specifications vs the general "contraindications"? Is latiex anaphylaxis included in the ACIP recommendations? 5. **Difference from standard:** Please explain why transplantation is an exclusion and not a medical contraindication. (*Also asked by the Committee in the accompanying memo.*) 6. How are patients with multiple hospitalizations in the Oct-March timeframe handled? (*Also asked by the Committee in the accompanying memo.*)

Response – Plan to address inconsistency or rationale for inconsistency

1. For the inpatient measures, we look at inpatient hospitalizations, not individual patients per se. If there are multiple inpatient hospitalizations, we look to see that quality care is provided each time. For a case in which a patient had an inpatient hospitalization multiple times during a single flu season, the status would be assessed at each discharge and if indicated, they should receive the vaccine. The measures included in the Hospital Inpatient Reporting Program, formerly the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program looks at each discharge, not each patient. Currently there is no way to "link" hospitalizations for the individual measures required as a part of the IQR program.

2. Please see Exclusions. Patients with hospital discharges October 1 though March 31, when there is documentation the provider's vaccine has been ordered but the provider has not yet received.

3. 2008, CMS along with partners including The Joint Commission came to agreement on harmonized vaccination measures across settings (hospitals, nursing homes, home health agencies) that were incorporated into the NQF's National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations (December 2008). The performance measures were aligned with recommendations from the Advisory Committee on Immunization Practices. At that time, the consensus standards created four numerator categories for influenza and pneumococcal vaccination:

- Vaccinated during admission
- Vaccine received prior to admission
- Patient refusal
- Patient contraindication

The data collection tools and analytic algorithms allow for stratification and reporting of the each of the numerator categories, and allow for the calculation and reporting of a single overall measure rate.

CMS is still working out how they will be able to report the stratification on Hospital Compare.

4. This exclusion was implemented because one of the vaccine companies uses latex in the rubber stoppers of their pre-filled syringes. So this was a packaging issue. When we discussed this issue with our TEP, they recommended we add the latex anaphylaxis exclusion. How are the other measures handling this issue? In the days of Value-Based Purchasing, CMS must address issues such as this.

5. Using transplantation as an exclusion allows the case to be excluded using ICD-9/ICD-10 codes. These cases can be excluded prior to the abstractor abstracting the case, thus decreasing abstractor burden and abstractor mistakes.

Transplantation is not a contraindication to vaccination (there are no reported complications of vaccination of a transplant patients). However, the effectiveness (antibody response) of the influenza or pneumococcal vaccine may be blunted in a patient who is undergoing organ transplant due to immunosuppression used for these patients. In consultation with our expert panel which included strong representation from the Centers for Disease Control and Prevention, we made the decision to exclude from the denominator those patients who are undergoing organ transplantation during the hospitalization. Ideally these patients are vaccinated prior to their hospitalization for transplant before they undergo intense immunosuppression. We routinely encourage transplant centers in our educational efforts to vaccinate patients at the earliest point when they are identified as candidates for transplant.

6. For the inpatient measures, we look at inpatient hospitalizations, not individual patients per se. If there are multiple inpatient hospitalizations, we look to see that quality care is provided each time. For

a case in which a patient had an inpatient hospitalization multiple times during a single flu season, the status would be assessed at each discharge and if indicated, they should receive the vaccine. A case would pass the measure if any of the following were documented,

- Influenza vaccine was given during this hospitalization
- Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization
- Documentation of patient's or caregiver's refusal of influenza vaccine
- There was documentation of an allergy/sensitivity to influenza vaccine, anaphylactic latex allergy or anaphylactic allergy to eggs OR is not likely to be effective because of bone marrow transplant within the past 6 months OR history of Guillian-Barre Syndrome within 6 weeks after a previous influenza vaccination

Currently there is no way to "link" hospitalizations for the individual measures required as a part of the IQR program. However, as noted above, if a patient is vaccinated during the first of a series of admissions during flu season, the hospital simply needs to document prior vaccination for that flu season and the case will pass the measure for each admission.

Side-by-Side Comparison: Specifications for Pneumonia Vaccination Measures

	STANDARD	1653: HOSPITAL (CMS/OFMQ)
NUMERATOR	Number of persons specified in the denominator who • ever received the PPV23(pneumococcal polysaccharide) vaccine, documented administration by the provider or patient (or responsible party/legal guardian) reported receipt from another provider (computed & reported separately) OR • were assessed and offered but declined the vaccination (computed and reported separately) OR • were assessed and determined to have medical contraindication(s) of anaphylactic hypersensitivity to component(s) of the vaccine, or bone marrow transplant within the past 12 months (<12 months prior to encounters during the measurement year), or receiving course of chemotherapy or radiation therapy (<2 weeks prior to encounters during the measurement year) (computed and reported separately	Inpatient discharges who were screened for PPV23 status and received PPV23 prior to discharge if indicated. *The following patients are included in the numerator; Patients who received PPV23 during this hospitalization, Patients who receive PPV23 anytime in the past, Patients who were offered and declined the PPV during this hospitalization and Patients who have an allergy/sensitivity to the vaccine or the vaccine is not likely to be effective due to the following; hypersensitivity to component(s) of the vaccine, bone marrow transplants within the past 12 months, receipt of chemotherapy or radiation during this hospitalization or less thn 2 weeks prior to this hospitalization or received the shingles vaccine (Zostavax) within the last 4 weeks prior to this hospitalization. *Extracted from the numerator details.
DENOMINATOR	Number of persons • in a facility, agency, or practice with an encounter (or in a defined population) during the measurement year (OR for health plan measures, enrolled with a plan during measurement year) • who is age 65 or older OR • resides in a long-term care facility (including nursing homes and skilled nursing facilities) OR • is age 5-64 with prevalent high-risk conditions of diabetes, nephritic syndrome, end-stage renal disease (ESRD), congestive heart failure (CHF), asthma, chronic obstructive pulmonary disease (COPD), human immunodeficiency virus (HIV), asplenia. (These conditions should be included in a comprehensive measure, but are not intended to prevent focusing on a specific condition.	Inpatient discharges 65 years of age and older and 6-64 years of age who have a high risk condition. *All patients 65 years of age and older and 6-64 years of age who have a high risk condition (diabetes, nephric syndrome, ESRD, CHF, COPD, HIV or asplenia, see below for codes) are included in the denominator except the following; patients less than 6 years of age, patients who expire prior to hospital discharge, patients who are pregnant and patients with an organ transplant during the current hospitalization. See attachments of the ICD-9 and ICD-10 tables for the high risk conditions. The following data elements are needed for the denominator; Admission Date, Birthdate, Discharge Disposition, ICD-9-CM Other Diagnosis Codes, ICD-9-CM Principal Diagnosis Codes (or ICD-10-CM Principal or Other depending) *Extracted from the denominator details.

EXCLUSIONS	Hospital patients who died before discharge.	Patients who expire prior to hospital discharge and patients with an organ transplant during the current hospitalization.
COMMENTS		1. **Difference from standard:** The numerator statement should move the details of the included population up front. The numerator should be expressed in terms of the patient, not discharge status. 2. **Difference from standard:** The age ranges as currently specified in the submission are 65 years of age and older and 6-64 years of age. Why isn't the lower age for patients with a medical condition harmonized to age 5 years? *Five years is consistent with ACIP and NQF's standard specifications and with other similar measures. (Also asked by the Committee in the accompanying memo.)* 3. **Difference from standard:** Are the stratification details intended to be the numerator categories specified in the standard specifications? Will they be computed and reported separately as indicated in the standard specifications? *(Also asked by the Committee in the accompanying memo.)* 4. **Difference from standard:** Please explain why transplantation is an exclusion and not a medical contraindication. *(Also asked by the Committee in the accompanying memo.)* 5. How are patients with multiple hospitalizations during the calendar year assessed? *(Also asked by the Committee in the accompanying memo.)*

Response – Plan to address inconsistency or rationale for inconsistency

1. For the inpatient measures, we look at inpatient hospitalizations, not individual patients per se. If there are multiple inpatient hospitalizations, we look to see that quality care is provided each time. For a case in which a patient had an inpatient hospitalization multiple times during a single flu season, the status would be assessed at each discharge and if indicated, they should receive the vaccine. The measures included in the Hospital Inpatient Reporting Program, formerly the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program looks at each discharge, not each patient. Currently there is no way to "link" hospitalizations for the individual measures required as a part of the IQR program.

2. The national recommendations to vaccinate children with the pneumococcal conjugate vaccine (PCV13) make implementation of the measure for delivery of PPSV23 for 5 year old patients more challenging. Because PPSV23 needs to be delayed at least 8 weeks after the delivery of the last dose of PCV13, it is possible for a child who recently received PCV13 (near their 5th birthday) to be hospitalized within 8 weeks of their previous PCV13 dose. In consultation with our expert panel, the decision was made to limit the denominator population for the measure to patients who were 6 years of age and older.

3. 2008, CMS along with partners including The Joint Commission came to agreement on harmonized vaccination measures across settings (hospitals, nursing homes, home health agencies) that were incorporated into the NQF's National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations (December 2008). The performance measures were aligned with recommendations from the Advisory Committee on Immunization Practices. At that time, the consensus standards created four numerator categories for influenza and pneumococcal vaccination:

- Vaccinated during admission
- Vaccine received prior to admission
- Patient refusal
- Patient contraindication

The data collection tools and analytic algorithms allow for stratification and reporting of the each of the numerator categories, and allow for the calculation and reporting of a single overall measure rate.

CMS is still working out how they will be able to report the stratification on Hospital Compare.

4. Using transplantation as an exclusion allows the case to be excluded using ICD-9/ICD-10 codes. These cases can be excluded prior to the abstractor abstracting the case, thus decreasing abstractor burden and abstractor mistakes.

Transplantation is not a contraindication to vaccination (there are no reported complications of vaccination of a transplant patients). However, the effectiveness (antibody response) of the influenza or pneumococcal vaccine may be blunted in a patient who is undergoing organ transplant due to immunosuppression used for these patients. In consultation with our expert panel which included strong representation from the Centers for Disease Control and Prevention, we made the decision to exclude from the denominator those patients who are undergoing organ transplantation during the hospitalization. Ideally these patients are vaccinated prior to their hospitalization for transplant before they undergo intense immunosuppression. We routinely encourage transplant centers in our educational efforts to vaccinate patients at the earliest point when they are identified as candidates for transplant.

5. For the inpatient measures, we look at inpatient hospitalizations, not individual patients per se. If there are multiple inpatient hospitalizations, we look to see that quality care is provided each time. For

a case in which a patient had an inpatient hospitalization multiple times during a single flu season, the status would be assessed at each discharge and if indicated, they should receive the vaccine. A case would pass the measure if any of the following were documented,

- Influenza vaccine was given during this hospitalization
- Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization
- Documentation of patient's or caregiver's refusal of influenza vaccine
- There was documentation of an allergy/sensitivity to influenza vaccine, anaphylactic latex allergy or anaphylactic allergy to eggs OR is not likely to be effective because of bone marrow transplant within the past 6 months OR history of Guillian-Barre Syndrome within 6 weeks after a previous influenza vaccination

Currently there is no way to "link" hospitalizations for the individual measures required as a part of the IQR program. However, as noted above, if a patient is vaccinated during the first of a series of admissions during flu season, the hospital simply needs to document prior vaccination for that flu season and the case will pass the measure for each admission.