



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

NQF #: 0002

Corresponding Measures:

De.2. Measure Title: Appropriate Testing for Children with Pharyngitis

Co.1.1. Measure Steward: National Committee for Quality Assurance

De.3. Brief Description of Measure: The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

1b.1. Developer Rationale: Antimicrobial resistance is widely recognized as a public health threat and appropriate use of antibiotics is an important measure of quality of care. In children less than 15 years-old, pharyngitis accounts for the second highest number of antibiotic prescriptions for acute respiratory infections. However, many children and adolescents inappropriately receive antibiotics before a bacterial etiology is confirmed. Both the Infectious Diseases Society of America (IDSA) and American Heart Association (AHA) guidelines recommend a throat culture and/or rapid antigen detection test (RADT) for group A streptococcal (GAS) pharyngitis once viral etiology is ruled out. Only those children who have GAS infection confirmed should be prescribed an antibiotic. Both guidelines recommend penicillin and amoxicillin as choice treatment. For those allergic to penicillin, both recommend a first generation cephalosporin, clindamycin or clarithromycin or azithromycin instead.

S.4. Numerator Statement: A group A streptococcus test (Group A Strep Tests Value Set) in the seven-day period from three days prior to the Index Episode Start Date (IESD) through three days after the IESD.

Codes are detailed in the attached value set directory (VSD).

S.7. Denominator Statement: Children age 2 years as of July 1 of the year prior to the measurement year to 18 years as of June 30 of measurement year who had an outpatient or ED visit with only a diagnosis of pharyngitis and were dispensed an antibiotic for the episode of care during the 6 months prior to through the 6 months after the beginning of the measurement year.

S.10. Denominator Exclusions: 1) Exclude encounters with more than one diagnosis and ED visits that result in an inpatient admission.

2) Exclude episodes if the patient did not receive antibiotics on or within three days after the date of service.

3) Exclude episodes where a new or refill prescription for an antibiotic medication (Table CWP-C) was filled 30 days prior to the date of service or which was active on the date of service.

De.1. Measure Type: Process

S.23. Data Source: Claims, Electronic Health Data

S.26. Level of Analysis: Health Plan, Integrated Delivery System

IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Aug 10, 2009

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[0002_Evidence_Submission_Form.docx](#)

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)

Antimicrobial resistance is widely recognized as a public health threat and appropriate use of antibiotics is an important measure of quality of care. In children less than 15 years-old, pharyngitis accounts for the second highest number of antibiotic prescriptions for acute respiratory infections. However, many children and adolescents inappropriately receive antibiotics before a bacterial etiology is confirmed. Both the Infectious Diseases Society of America (IDSA) and American Heart Association (AHA) guidelines recommend a throat culture and/or rapid antigen detection test (RADT) for group A streptococcal (GAS) pharyngitis once viral etiology is ruled out. Only those children who have GAS infection confirmed should be prescribed an antibiotic. Both guidelines recommend penicillin and amoxicillin as choice treatment. For those allergic to penicillin, both recommend a first generation cephalosporin, clindamycin or clarithromycin or azithromycin instead.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

The following data are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. Performance data are summarized at the health plan level and summarized by number of plans reporting, mean, standard deviation, minimum health plan performance, maximum health plan performance and performance at the 10th, 25th, 50th, 75th and 90th percentile. Data are stratified by year and product line (i.e. commercial and Medicaid).

*Higher score= better performance

N= Number of plans reporting

Commercial Rate (HMO and PPO Combined)

YEAR	N	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX
2012	401	79.8%	10.8%	2.23%	67.0%	75.4%	81.0%	87.3%	91.1%	96.6%
2013	406	79.6%	11.7%	2.79%	67.4%	74.8%	81.5%	87.7%	90.6%	96.7%
2014	405	79.6%	11.2%	2.32%	66.5%	74.2%	81.7%	87.2%	91.0%	97.3%

Medicaid Rate (HMO and PPO Combined)

YEAR	N	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX
2012	150	66.7%	15.4%	12.0%	50.3%	58.5%	69.8%	76.4%	83.7%	96.9%
2013	160	68.0%	14.9%	11.9%	51.1%	61.0%	70.2%	77.9%	85.1%	99.4%
2014	171	66.4%	15.5%	12.9%	49.0%	56.6%	68.4%	78.0%	83.5%	91.8%

Medicaid Rate

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity,

gender, age, insurance status, socioeconomic status, and/or disability. (This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

Results from a study assessing antibiotic prescribing and diagnosis rates in children with pharyngitis showed that black children were less likely to receive a diagnosis of group A streptococcal pharyngitis (2.3% vs 3.7%). Results also showed that when an antibiotic was prescribed, black children were less likely than non-black children to receive a broad-spectrum antibiotic prescription at any visit (34% vs 36.9%).

Gerber et al. Racial Differences in Antibiotic Prescribing by Primary Care Pediatricians. *Pediatrics*. 2013; 131:677–684.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, Patient/societal consequences of poor quality

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.

List citations in 1c.4.

Antimicrobial resistance is widely recognized as a public health threat and appropriate use of antibiotics is an important measure of quality of care. In children less than 15 years-old, pharyngitis accounts for the second highest number of antibiotic prescriptions for acute respiratory infections. However, many children and adolescents inappropriately receive antibiotics before a bacterial etiology is confirmed.

The total economic cost of antibiotic resistance to the U.S. economy has been difficult to calculate. Estimates vary but have ranged as high as \$20 billion in excess direct healthcare costs, with additional costs to society for lost productivity as high as \$35 billion a year (2008 dollars).

1c.4. Citations for data demonstrating high priority provided in 1a.3

Centers for Disease Control and Prevention. 2013. Antibiotic Resistance Threats in the United States, 2013.

<http://www.cdc.gov/drugresistance/threat-report-2013/pdf/ar-threats-2013-508.pdf> (Accessed March 26, 2015).

Gerber et al. Prevention of Rheumatic Fever and Diagnosis and Treatment of Acute Streptococcal Pharyngitis. *Circulation*. 2009;119: 1541-1551.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

N/A

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Ears, Nose, Throat (ENT) : Pharyngitis

De.6. Non-Condition Specific (check all the areas that apply):

Safety : Overuse

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

N/A

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: 0002_CWP_Value_Sets_Final.xlsx

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

This measure is currently endorsed; there have not been any major updates to the measure since original endorsement (January 2009)

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

A group A streptococcus test (Group A Strep Tests Value Set) in the seven-day period from three days prior to the Index Episode Start Date (IESD) through three days after the IESD.

Codes are detailed in the attached value set directory (VSD).

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

A 12 month period that begins 6 months prior to the beginning of the measurement year through the 6 months after the beginning of the measurement year.

S.6. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Index Episode Start Date: The earliest date of service for any outpatient or ED visit during the 6 months prior to the beginning of the measurement year through 6 months after the beginning of the measurement year with only a diagnosis of pharyngitis that meets the following criteria:

- 1) Linked to a dispensed antibiotic prescription on or during the three days after the date of service.
- 2) A 30-day negative medication history prior to the date of service

Negative Medication History- To qualify, a patient must have a clean period of 30 days prior to the date of service, when the patient had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.

AND

No prescriptions filled more than 30 days prior to the date of service that are active* on the date of service.

*A prescription is considered “active” if the “days supply” indicated on the date when the patient filled the prescription is the number of days or more than the number of days between the dispensed date and the date of the episode.

S.7. Denominator Statement *(Brief, narrative description of the target population being measured)*

Children age 2 years as of July 1 of the year prior to the measurement year to 18 years as of June 30 of measurement year who had an outpatient or ED visit with only a diagnosis of pharyngitis and were dispensed an antibiotic for the episode of care during the 6 months prior to through the 6 months after the beginning of the measurement year.

S.8. Target Population Category *(Check all the populations for which the measure is specified and tested if any):*

Children

S.9. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

Determine the earliest eligible episode using the steps below.

Step 1: Identify all patients who had an outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the 6 months prior to the beginning of the measurement year through the 6 months after the beginning of the measurement year with only a diagnosis of pharyngitis (Pharyngitis Value Set).

Codes are detailed in the attached value set directory (VSD).

Exclude encounters with more than one diagnosis and ED visits that result in an inpatient admission in the denominator.

Step 2: Determine all pharyngitis episode dates. For each patient identified in Step 1, determine all outpatient or ED claims/encounters with only a diagnosis of pharyngitis.

Step 3: For each episode date with a qualifying diagnosis, determine if antibiotics (Table CWP-C) were prescribed on or within three days after the episode date. Exclude dates if the patient did not receive antibiotics on or within three days after the date of service.

ANTIBIOTIC MEDICATIONS (Table CWP-C):

Aminopenicillins: Amoxicillin, Ampicillin

Beta-lactamase inhibitors: Amoxicillin-clavulanate

First generation cephalosporins: Cefadroxil, Cefazolin, Cephalexin

Folate antagonist: Trimethoprim

Lincomycin derivatives: Clindamycin

Macrolides: Azithromycin, Clarithromycin, Erythromycin, Erythromycin ethylsuccinate, Erythromycin lactobionate, Erythromycin stearate

Miscellaneous antibiotics: Erythromycin-sulfisoxazole

Natural penicillins: Penicillin G potassium, Penicillin G sodium, Penicillin V potassium

Quinolones: Ciprofloxacin, Levofloxacin, Moxifloxacin, Ofloxacin

Second generation cephalosporins: Cefaclor, Cefprozil, Cefuroxime, Loracarbef

Sulfonamides: Sulfamethoxazole-trimethoprim, Sulfisoxazole

Tetracyclines: Doxycycline, Minocycline, Tetracycline

Third generation cephalosporins: Cefdinir, Cefixime, Cefpodoxime, Ceftibuten, Cefditoren, Ceftriaxone

S.10. Denominator Exclusions (Brief narrative description of exclusions from the target population)

- 1) Exclude encounters with more than one diagnosis and ED visits that result in an inpatient admission.
- 2) Exclude episodes if the patient did not receive antibiotics on or within three days after the date of service.
- 3) Exclude episodes where a new or refill prescription for an antibiotic medication (Table CWP-C) was filled 30 days prior to the date of service or which was active on the date of service.

S.11. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

N/A

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)

This measure is stratified by product line for health plan accountability. Product Lines: Medicaid and Commercial.

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

N/A

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

Provided in response box S.15a

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

N/A

S.16. Type of score:

Rate/proportion

If other:

S.17. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.18. 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.)

Refer to items S.9 for additional denominator details and attached value set directory for codes.

Step 1. Determine the eligible population. The eligible population is all patients who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement.

Step 2. Exclude from the eligible population patients whom administrative system data identified as not appropriate for the measure.

Step 3. Search administrative systems to identify numerator events for all patients in the eligible population.

Step 4. If applicable, for patients for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured. Note: This step applies only to measures for which exclusions are specified.

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)
No diagram provided

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

N/A

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

N/A

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

N/A

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Claims, Electronic Health Data

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system. This measure is also collected in CMS' Physician Quality Reporting System (PQRS).

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Health Plan, Integrated Delivery System

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Outpatient Services

If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

N/A

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

MeasTesting_CWP_3-23-15_4-9-15.docx

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields? (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*)

ALL data elements are in defined fields in electronic claims

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

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

- 1) information practices and control procedures
- 2) sampling methods and procedures
- 3) data integrity
- 4) compliance with HEDIS specifications
- 5) analytic file production
- 6) reporting and documentation

In addition to the HEDIS Audit, NCQA provides a system to allow "real-time" feedback from measure users. Our Policy Clarification

Support System receives thousands of inquiries each year on over 100 measures. Through this system NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measure. This system is vital to the regular re-evaluation of NCQA measures.

Input from NCQA auditing and the Policy Clarification Support System informs the annual updating of all HEDIS measures including updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence. During re-evaluation information from NCQA auditing and Policy Clarification Support System is used to inform evaluation of the scientific soundness and feasibility of the measure.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Planned	Current Use (for current use provide URL)
	Public Reporting Health Plan Ranking http://reportcard.ncqa.org/plan/external/plansearch.aspx Annual State of Health Care Quality http://www.ncqa.org/Portals/0/Newsroom/2014/SOHC-web.pdf Quality Compass http://www.ncqa.org/tabid/177/Default.aspx Payment Program California Value Based P4P program (Integrated Healthcare Association (IHA)) http://www.iha.org/pdfs_documents/p4p_california/MY-2015-Measure-Set-20150127.pdf Meaningful Use Stage 2 (EHR Incentive Program) (CMS eCQM #146v3) http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_EP_MeasuresTable_June2013.pdf http://www.cms.gov/apps/ama/license.asp?file=PQRS/downloads/2015_PQRS_IndividualMeasureSpecs_SupportingDocs_111214.zip Physician Quality Reporting Program (PQRS) (#066) 2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures (PDF)

Regulatory and Accreditation Programs
 Health Insurance Marketplace: Quality Rating System (2015)
<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2015-QRS-Measure-Technical-Specifications.pdf>

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

HEALTH PLAN RANKINGS/REPORT CARDS: This measure is used to calculate health plan rankings which are reported in Consumer Reports and on the NCQA website. These rankings are based on performance on HEDIS measures among other factors. In 2014, a total of 408 Medicare Advantage health plans, 507 commercial health plans and 136 Medicaid health plans across 50 states were included in the rankings.

ANNUAL STATE OF HEALTH CARE REPORT: This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2014 the report included measures on 14 million Medicare Advantage beneficiaries in 515 Medicare Advantage health plans, 108 million members in 416 commercial health plans, and 20 million Medicaid beneficiaries in 237 plans across 50 states.

QUALITY COMPASS: This measure is used in Quality Compass which is an indispensable tool used for selecting a health plan, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

CALIFORNIA VALUE BASED P4P PROGRAM: This measure is used in the California P4P program, which is the largest non-governmental physician incentive program in the United States. Managed by the Integrated Healthcare Association on behalf of eight health plans, the program reports performance for about 35,000 physicians in nearly 200 physician groups and includes 30 measures adapted from HEDIS. The program has recently created Value Based P4P, which will hold physicians accountable for costs as well as quality of care through health plan efficiency measures and incentives using a shared savings model.

CMS MEANINGFUL USE STAGE 2 (EHR INCENTIVE PROGRAM): This measure is used in the CMS Meaningful Use Stage 2 program. This voluntary program provides incentive payments to providers and hospitals that demonstrate they are using EHRs to improve patient health. The program's step-wise phases that encourage capturing health information in a standardized format, reporting quality measures, and demonstrating improved health outcomes, use of decision support for high-priority conditions, access to self-management tools and improved population health.

CMS PHYSICIAN QUALITY REPORTING SYSTEM: This measure is used in CMS' Physician Quality Reporting System (PQRS), which uses incentive payments and adjustments to encourage quality measures reporting at the provider and group levels. NCQA stewards 34 measures and co-stewards 10 with the American Medical Association in this set.

CMS HEALTH INSURANCE MARKET QUALITY RATING SYSTEM: This measure is used in the CMS developed, Quality Reporting Rating System (QRS) set of measures. The QRS measure set consists of measures that address areas of clinical quality management; enrollee experience; and plan efficiency, affordability and management. The measure set includes 32 NCQA's HEDIS measures.

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

N/A

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

N/A

4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance

results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

Performance was steady over the past three years for commercial and Medicaid plans (HMO and PPO combined). Average performance was about 80% for Commercial plans and 67% for Medicaid plans. In 2014, commercial plans in the 10th percentile had an average rate of 67% and Medicaid plans had an average of 49%. These rates suggest opportunity for continued performance improvements.

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

N/A

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

N/A

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

No

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications completely harmonized?

No

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

N/A

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

N/A

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

No appendix Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [National Committee for Quality Assurance](#)

Co.2 Point of Contact: [Bob, Rehm, \[nqf@ncqa.org\]\(mailto:nqf@ncqa.org\), 202-955-1728-](#)

Co.3 Measure Developer if different from Measure Steward: [National Committee for Quality Assurance](#)

Co.4 Point of Contact: [Bob, Rehm, \[nqf@ncqa.org\]\(mailto:nqf@ncqa.org\), 202-955-1728-](#)

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2004

Ad.3 Month and Year of most recent revision: 01, 2012

Ad.4 What is your frequency for review/update of this measure? Approximately every 3 years, sooner if the clinical guidelines have changed significantly.

Ad.5 When is the next scheduled review/update for this measure? 07, 2016

Ad.6 Copyright statement: © 2004 by the National Committee for Quality Assurance

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Ad.7 Disclaimers: These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. THE MEASURES AND SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.

Ad.8 Additional Information/Comments: Publication of each Measure is to be accompanied by the following notice:

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