



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 sub criterion 1b).

Brief Measure Information

NQF #: 0034

Corresponding Measures:

Measure Title: Colorectal Cancer Screening (COL)

Measure Steward:

sp.02. Brief Description of Measure: The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.

1b.01. Developer Rationale: This measure encourages screening for colorectal cancer so that it can be prevented or detected early when it is most treatable, which reduces deaths associated with colorectal cancer.

sp.12. Numerator Statement: Patients who received one or more screenings for colorectal cancer according to clinical guidelines.

sp.14. Denominator Statement: Patients 51–75 years of age

sp.16. Denominator Exclusions: This measure excludes patients with a history of colorectal cancer or total colectomy. The measure also excludes patients who use hospice services or are enrolled in an institutional special needs plan (SNP) or living long-term in an institution any time during the measurement year.

Measure Type: Process

sp.28. Data Source:

Paper Medical Records

Claims

Electronic Health Data

sp.07. Level of Analysis:

Integrated Delivery System

Health Plan

IF Endorsement Maintenance – Original Endorsement Date: 2009-08-10 12:00 AM

Most Recent Endorsement Date: 6/6/2018 5:02:50 PM

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

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

sp.03. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?:

1. 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 sub criteria to pass this criterion and be evaluated against the remaining criteria

1ma.01. Indicate whether there is new evidence about the measure since the most recent maintenance evaluation. If yes, please briefly summarize the new evidence, and ensure you have updated entries in the Evidence section as needed.

[Response Begins]

Yes

[Response Ends]

Please separate added or updated information from the most recent measure evaluation within each question response in the Importance to Measure and Report: Evidence section. For example:

Current Submission:

Updated evidence information here.

Previous (Year) Submission:

Evidence from the previous submission here.

1a.01. Provide a logic model.

Briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient's health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.

[Response Begins]

[Response Ends]

1a.02. Select the type of source for the systematic review of the body of evidence that supports the performance measure.

A systematic review is a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies. It may include a quantitative synthesis (meta-analysis), depending on the available data.

[Response Begins]

[Response Ends]

If the evidence is not based on a systematic review, skip to the end of the section and do not complete the repeatable question group below. If you wish to include more than one systematic review, add additional tables by clicking "Add" after the final question in the group.

Evidence - Systematic Reviews Table (Repeatable)

Group 1 - Evidence - Systematic Reviews Table

1a.03. Provide the title, author, date, citation (including page number) and URL for the systematic review.

[Response Begins]

[Response Ends]

1a.04. Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the systematic review.

[Response Begins]

[Response Ends]

1a.05. Provide the grade assigned to the evidence associated with the recommendation, and include the definition of the grade.

[Response Begins]

[Response Ends]

1a.06. Provide all other grades and definitions from the evidence grading system.

[Response Begins]

[Response Ends]

1a.07. Provide the grade assigned to the recommendation, with definition of the grade.

[Response Begins]

[Response Ends]

1a.08. Provide all other grades and definitions from the recommendation grading system.

[Response Begins]

[Response Ends]

1a.09. Detail the quantity (how many studies) and quality (the type of studies) of the evidence.

[Response Begins]

[Response Ends]

1a.10. Provide the estimates of benefit, and consistency across studies.

[Response Begins]

[Response Ends]

1a.11. Indicate what, if any, harms were identified in the study.

[Response Begins]

[Response Ends]

1a.12. Identify any new studies conducted since the systematic review, and indicate whether the new studies change the conclusions from the systematic review.

[Response Begins]

[Response Ends]

1a.13. If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, describe the evidence on which you are basing the performance measure.

[Response Begins]

[Response Ends]

1a.14. Briefly synthesize the evidence that supports the measure.

[Response Begins]

[Response Ends]

1a.15. Detail the process used to identify the evidence.

[Response Begins]

[Response Ends]

1a.16. Provide the citation(s) for the evidence.

[Response Begins]

[Response Ends]

1b.01. Briefly explain the rationale for this measure.

Explain how the measure will improve the quality of care, and list the benefits or improvements in quality envisioned by use of this measure.

[Response Begins]

This measure encourages screening for colorectal cancer so that it can be prevented or detected early when it is most treatable, which reduces deaths associated with colorectal cancer.

[Response Ends]

1b.02. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.

Include mean, std dev, min, max, interquartile range, and 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 include. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.

[Response Begins]

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 mean, standard deviation, minimum health plan performance, maximum health plan performance and performance at 10th, 25th, 50th, 75th, and 90th percentile. Data are stratified by year and product line (i.e. commercial, Medicare).

Colorectal Cancer Screening – commercial Rate (HMO and PPO Combined)

MEASUREMENT YEAR | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | Interquartile Range

2014 | 61.2% | 8.9% | 50.4% | 54.9% | 60.3% | 67.6% | 72.0% | 12.7

2015 | 60.0% | 9.2% | 49.2% | 54.1% | 59.5% | 66.3% | 71.6% | 12.2

2016 | 60.1% | 9.6% | 48.4% | 53.9% | 60.1% | 66.4% | 72.2% | 12.5

Colorectal Cancer Screening – Medicare Rate (HMO and PPO Combined)

MEASUREMENT YEAR | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | Interquartile Range

2014 | 65.5% | 11.6% | 51.6% | 59.9% | 66.9% | 73.1% | 77.4% | 13.2

2015 | 67.2% | 10.9% | 52.6% | 60.9% | 68.1% | 74.5% | 79.6% | 13.7

2016 | 67.7% | 12.4% | 50.8% | 60.9% | 69.9% | 76.4% | 81.0% | 15.5

The data references are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. In 2016, HEDIS measures covered 114.2 million commercial health plan beneficiaries and 17.6 million Medicare beneficiaries. Below is a description of the denominator for this measure. It includes the number of health plans included in HEDIS data collection and the mean eligible population for the measure across health plans.

Colorectal Cancer Screening – commercial

YEAR | N Plans | Median Denominator Size per plan

2014 | 401 | 411

2015 | 415 | 411

2016 | 412 | 411

Colorectal Cancer Screening – Medicare

YEAR | N Plans | Median Denominator Size per plan

2014 | 449 | 396

2015 | 440 | 408

2016 | 459 | 411

[Response Ends]

1b.03. If no or limited performance data on the measure as specified is reported above, 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. Include citations.

[Response Begins]**[Response Ends]**

1b.04. 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.

Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included. Include mean, std dev, min, max, interquartile range, and scores by decile. For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.

[Response Begins]

HEDIS data are stratified by type of insurance (e.g. Commercial, Medicaid, Medicare). While not specified in the measure, this measure can also be stratified by demographic variables, such as race/ethnicity or socioeconomic

status, in order to assess the presence of health care disparities, if the data are available to a plan. The HEDIS Race/Ethnicity Diversity of Membership and the Language Diversity of Membership measures were designed to promote standardized methods for collecting these data and follow Office of Management and Budget and Institute of Medicine guidelines for collecting and categorizing race/ethnicity and language data. In addition, NCQA's Multicultural Health Care Distinction Program outlines standards for collecting, storing, and using race/ethnicity and language data to assess health care disparities. Based on extensive work by NCQA to understand how to promote culturally and linguistically appropriate services among plans and providers, we have many examples of how health plans have used HEDIS measures to design quality improvement programs to decrease disparities in care.

[Response Ends]

1b.05. If no or limited data on disparities from the measure as specified is reported above, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in above.

[Response Begins]

Researchers have identified disparities in the rate of colorectal cancer screening based on race, ethnicity, income, education and English language proficiency. Racial/ethnic minorities, most notably Hispanic-Spanish, had lower colorectal cancer screening rates than Whites in 2010 (30.6 percent Hispanic-Spanish, 47.2 percent Asian, 49.5 percent American Indian/Alaska Native, 52.5 percent Hispanic-English and 54.6 percent Native Hawaiian/Pacific Islander, compared to 62 percent White) (Liss and Baker, 2014). Low-income and low-literacy populations also have low colorectal cancer screening rates. The percentage of people who are up-to-date with screening has been consistently lower for people with a family income below 200 percent of the federal poverty level compared to people with a family income greater than or equal to 500 percent of the federal poverty level (In 2008, screening rate of 40.1 percent for people below 200 percent federal poverty level and 66.0 percent for people greater than or equal to 500 percent federal poverty level). Similarly, the percentage of people who are up-to-date with screening has been consistently lower for people with less than a high school education compared to people with greater than a high school education (screening rate of 37.5 percent in less than high school and 62.0 percent in greater than high school). (Klabunde et al, 2011) Limited-English proficient populations exhibit lower colorectal cancer screening rates compared to English proficient populations. In 2006, 33 percent of Latinos responding in Spanish reported having a screen, compared to 51 percent of Latinos responding in English and 62 percent of English-speaking non-Latinos. (Diaz et al, 2008)

Brenner AT, Hoffman R, McWilliams A, Pignone MP, Rhyne RL, Tapp H, Weaver MA, Callan D, de Hernandez BU, Harbi K, Reuland DS. Colorectal cancer screening in vulnerable patients: promoting informed and shared decisions. *American Journal of Preventive Medicine*. 2016;51(4)454-462.

Diaz JA, Roberts MB, Goldman RE, Weitzen S, Eaton CB. Effect of language on colorectal cancer screening among latinos and non-latinos. *Cancer epidemiology, biomarkers & prevention?: a publication of the American Association for Cancer Research, cosponsored by the American Society of Preventive Oncology*. 2008;17(8)2169-2173.

Klabunde CN, Cronin KA, Breen N, Waldron WR, Ambbs AH, Nadel MR. Trends in colorectal cancer test use among vulnerable populations in the U.S. *Cancer epidemiology, biomarkers & prevention?: a publication of the American Association for Cancer Research, cosponsored by the American Society of Preventive Oncology*. 2011;20(8):1611-1621.

Liss DT, Baker DW. Understanding current racial/ethnic disparities in colorectal cancer screening in the United States: the contribution of socioeconomic status and access to care. *American Journal of Preventive Medicine*. 2014;46(3):228-236.

Rice K, Gressard L, DeGroff A, Gersten J, Robie, J, Leadbetter S, Glover-Kudon R, Butterly L. Increasing colonoscopy

screening in disparate populations: results from an evaluation of patient navigation in the New Hampshire Colorectal Cancer Screening Program. Cancer. 2017;123(17)3356-3366.

[Response Ends]

2. 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 sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.

spma.01. Indicate whether there are changes to the specifications since the last updates/submission. If yes, update the specifications in the Measure Specifications section of the Measure Submission Form, and explain your reasoning for the changes below.

[Response Begins]

Yes

[Response Ends]

spma.02. Briefly describe any important changes to the measure specifications since the last measure update and provide a rationale.

For annual updates, please explain how the change in specifications affects the measure results. If a material change in specification is identified, data from re-testing of the measure with the new specifications is required for early maintenance review.

For example, specifications may have been updated based on suggestions from a previous NQF CDP review.

[Response Begins]

Since the last NQF review, two additional screening methods have been added to the measure, in alignment with updates to clinical guidelines. These changes were reviewed by stakeholder groups, vetted through a public comment period, and approved by our committees.

[Response Ends]

sp.01. Provide the measure title.

Measure titles should be concise yet convey who and what is being measured (see [What Good Looks Like](#)).

[Response Begins]

Colorectal Cancer Screening (COL)

[Response Ends]

sp.02. Provide a brief description of the measure.

Including type of score, measure focus, target population, timeframe, (e.g., Percentage of adult patients aged 18-75 years receiving one or more HbA1c tests per year).

[Response Begins]

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

[Response Ends]

sp.04. Check all the clinical condition/topic areas that apply to your measure, below.

Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.

Please do not select:

- *Surgery: General*

[Response Begins]

[Response Ends]

sp.05. Check all the non-condition specific measure domain areas that apply to your measure, below.

[Response Begins]

Primary Prevention

[Response Ends]

sp.06. Select one or more target population categories.

Select only those target populations which can be stratified in the reporting of the measure's result.

Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.

Please do not select:

- *Populations at Risk: Populations at Risk*

[Response Begins]

Elderly (Age >= 65)

[Response Ends]

sp.07. Select the levels of analysis that apply to your measure.

Check ONLY the levels of analysis for which the measure is SPECIFIED and TESTED.

Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.

Please do not select:

- *Clinician: Clinician*
- *Population: Population*

[Response Begins]

Health Plan

Integrated Delivery System

[Response Ends]

sp.08. Indicate the care settings that apply to your measure.

Check ONLY the settings for which the measure is SPECIFIED and TESTED.

[Response Begins]

Outpatient Services

[Response Ends]

sp.09. 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. If no URL is available, indicate "none available".

[Response Begins]

N/A

[Response Ends]

sp.12. Attach the data dictionary, code table, or value sets (and risk model codes and coefficients when applicable). Excel formats (.xlsx or .csv) are preferred.

Attach an excel or csv file; if this poses an issue, [contact staff](#). Provide descriptors for any codes. Use one file with multiple worksheets, if needed.

[Response Begins]

No data dictionary/code table – all information provided in the submission form

[Response Ends]

sp.13. State the numerator.

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).

DO NOT include the rationale for the measure.

[Response Begins]

Patients who received one or more screenings for colorectal cancer according to clinical guidelines.

[Response Ends]

sp.14. Provide details needed to calculate the numerator.

All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, 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 sp.11.

[Response Begins]

ADMINISTRATIVE:

Patients who received one or more screenings for colorectal cancer. Any of the following meet criteria:

-Fecal occult blood test (FOBT Value Set) during the measurement year.

- Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year.
- CT colonography (CT Colonography Value Set) during the measurement year or the four years prior to the measurement year.
- FIT-DNA test (FIT-DNA Value Set) during the measurement year or the two years prior to the measurement year.

MEDICAL RECORD:

Patients who received one or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test during the measurement year.
- Flexible sigmoidoscopy 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.
- CT colonography during the measurement year or the four years prior to the measurement year.
- FIT-DNA test 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 colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the “medical history” section of the record; if this

is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.

For pathology reports that do not indicate the type of screening and for incomplete procedures:

- Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy.
- Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy.

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (FIT). 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 of 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 meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion.

--FIT tests may require fewer than three samples. If the medical record indicates that an FIT was done, the member meets the screening criteria, regardless of how many samples were returned.

--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.

Do not count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

[Response Ends]

sp.15. State the denominator.

Brief, narrative description of the target population being measured.

[Response Begins]

Patients 51–75 years of age

[Response Ends]

sp.16. Provide details needed to calculate the denominator.

All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, 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 sp.11.

[Response Begins]

Patients 51–75 years of age as of the end of the measurement year (e.g. December 31).

[Response Ends]

sp.17. Describe the denominator exclusions.

Brief narrative description of exclusions from the target population.

[Response Begins]

This measure excludes patients with a history of colorectal cancer or total colectomy. The measure also excludes patients who use hospice services or are enrolled in an institutional special needs plan (SNP) or living long-term in an institution any time during the measurement year.

[Response Ends]

sp.18. Provide details needed to calculate the denominator exclusions.

All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, 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 sp.11.

[Response Begins]

Exclude patients with either of the following any time during the patient's history through December 31 of the measurement year:

- Colorectal cancer (Colorectal Cancer Value Set)
- Total colectomy (Total Colectomy Value Set)

Exclude patients who use hospice services any time during the measurement year (Hospice Value Set).

Exclude patients 65 and older who are enrolled in an institutional SNP or living long-term in an institution at any time during the measurement year.

[Response Ends]

sp.19. Provide all information required to stratify the measure results, if necessary.

Include the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate. Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format in the Data Dictionary field.

[Response Begins]

None

[Response Ends]

sp.20. Is this measure adjusted for socioeconomic status (SES)?

[Response Begins]

[Response Ends]

sp.21. Select the risk adjustment type.

Select type. Provide specifications for risk stratification and/or risk models in the Scientific Acceptability section.

[Response Begins]

No risk adjustment or risk stratification

[Response Ends]

sp.22. Select the most relevant type of score.

Attachment: If available, please provide a sample report.

[Response Begins]

Rate/proportion

[Response Ends]

sp.23. Select the appropriate interpretation of the measure score.

Classifies interpretation of score according to whether better quality or resource use is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score

[Response Begins]

Better quality = Higher score

[Response Ends]

sp.24. Diagram or describe the calculation of the measure score as an ordered sequence of steps.

Identify the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period of data, aggregating data; risk adjustment; etc.

[Response Begins]

Step 1. Determine the eligible population: identify patients 51-75 years of age by the end of the measurement year.

Step 2. Search for an exclusion in the patient's history: history of total colectomy or colorectal cancer. Exclude these patients from the eligible population.

Step 3. Determine numerator: the number of patients who have been screened for colorectal cancer by any of the included screening methods, within the associated time interval.

Step 4. Calculate the rate.

[Response Ends]

sp.27. If measure testing is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.

Examples of samples used for testing:

- Testing may be conducted on a sample of the accountable entities (e.g., hospital, physician). The analytic unit specified for the particular measure (e.g., physician, hospital, home health agency) determines the sampling strategy for scientific acceptability testing.
- The sample should represent the variety of entities whose performance will be measured. The [2010 Measure Testing Task Force](#) recognized that the samples used for reliability and validity testing often have limited generalizability because measured entities volunteer to participate. Ideally, however, all types of entities whose performance will be measured should be included in reliability and validity testing.
- The sample should include adequate numbers of units of measurement and adequate numbers of patients to answer the specific reliability or validity question with the chosen statistical method.
- When possible, units of measurement and patients within units should be randomly selected.

[Response Begins]

N/A

[Response Ends]

sp.30. Select only the data sources for which the measure is specified.

[Response Begins]

Claims

Electronic Health Data

Paper Medical Records

[Response Ends]

sp.31. Identify the specific data source or data collection instrument.

For example, provide the name of the database, clinical registry, collection instrument, etc., and describe how data are collected.

[Response Begins]

This measure is based on administrative claims and medical record documentation 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.

[Response Ends]

sp.32. Provide the data collection instrument.

[Response Begins]

No data collection instrument provided

[Response Ends]

2ma.01. Indicate whether additional empirical reliability testing at the accountable entity level has been conducted. If yes, please provide results in the following section, Scientific Acceptability: Reliability - Testing. Include information on all testing conducted (prior testing as well as any new testing).

Please separate added or updated information from the most recent measure evaluation within each question response in the Scientific Acceptability sections. For example:

Current Submission:

Updated testing information here.

Previous Submission:

Testing from the previous submission here.

[Response Begins]

Yes

[Response Ends]

2ma.02. Indicate whether additional empirical validity testing at the accountable entity level has been conducted. If yes, please provide results in the following section, Scientific Acceptability: Validity - Testing. Include information on all testing conducted (prior testing as well as any new testing).

Please separate added or updated information from the most recent measure evaluation within each question response in the Scientific Acceptability sections. For example:

Current Submission:

Updated testing information here.

Previous Submission:

Testing from the previous submission here.

[Response Begins]

Yes

[Response Ends]

2ma.03. For outcome, patient-reported outcome, resource use, cost, and some process measures, risk adjustment/stratification may be conducted. Did you perform a risk adjustment or stratification analysis?

[Response Begins]

[Response Ends]

2ma.04. For maintenance measures in which risk adjustment/stratification has been performed, indicate whether additional risk adjustment testing has been conducted since the most recent maintenance evaluation. This may include updates to the risk adjustment analysis with additional clinical, demographic, and social risk factors.

Please update the Scientific Acceptability: Validity - Other Threats to Validity section.

Note: This section must be updated even if social risk factors are not included in the risk adjustment strategy.

[Response Begins]

[Response Ends]

Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate fields in the Scientific Acceptability sections of the Measure Submission Form.

- Measures must be tested for all the data sources and levels of analyses that are specified. If there is more than one set of data specifications or more than one level of analysis, contact NQF staff about how to present all the testing information in one form.
- All required sections must be completed.
- For composites with outcome and resource use measures, Questions 2b.23-2b.37 (Risk Adjustment) also must be completed.
- If specified for multiple data sources/sets of specifications (e.g., claims and EHRs), Questions 2b.11-2b.13 also must be completed.
- An appendix for supplemental materials may be submitted (see Question 1 in the Additional section), but there is no guarantee it will be reviewed.
- Contact NQF staff with any questions. Check for resources at the [Submitting Standards webpage](#).
- For information on the most updated guidance on how to address social risk factors variables and testing in this form refer to the release notes for the [2021 Measure Evaluation Criteria and Guidance](#).

Note: The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the testing results for this measure meet NQF's evaluation criteria for testing.

2a. Reliability testing demonstrates the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period and/or that the measure score is precise. For instrument-based measures (including PRO-PMs) and composite performance measures, reliability should be demonstrated for the computed performance score.

2b1. Validity testing demonstrates that the measure data elements are correct and/or the measure score correctly reflects the quality of care provided, adequately identifying differences in quality. For instrument based measures (including PRO-PMs) and composite performance measures, validity should be demonstrated for the computed performance score.

2b2. Exclusions are supported by the clinical evidence and are of sufficient frequency to warrant inclusion in the specifications of the measure;

AND

If patient preference (e.g., informed decision-making) is a basis for exclusion, there must be evidence that the exclusion impacts performance on the measure; in such cases, the measure must be specified so that the information about patient preference and the effect on the measure is transparent (e.g., numerator category computed separately, denominator exclusion category computed separately).

2b3. For outcome measures and other measures when indicated (e.g., resource use):

- an evidence-based risk-adjustment strategy (e.g., risk models, risk stratification) is specified; is based on patient factors (including clinical and social risk factors) that influence the measured outcome and are present at start of care; 14,15 and has demonstrated adequate discrimination and calibration

OR

- rationale/data support no risk adjustment/ stratification.

2b4. Data analysis of computed measure scores demonstrates that methods for scoring and analysis of the specified measure allow for identification of statistically significant and practically/clinically meaningful 16 differences in performance;

OR

there is evidence of overall less-than-optimal performance.

2b5. If multiple data sources/methods are specified, there is demonstration they produce comparable results.

2b6. Analyses identify the extent and distribution of missing data (or nonresponse) and demonstrate that performance results are not biased due to systematic missing data (or differences between responders and non-responders) and how the specified handling of missing data minimizes bias.

2c. For composite performance measures, empirical analyses support the composite construction approach and demonstrate that:

2c1. the component measures fit the quality construct and add value to the overall composite while achieving the related objective of parsimony to the extent possible; and

2c2. the aggregation and weighting rules are consistent with the quality construct and rationale while achieving the related objective of simplicity to the extent possible.

(if not conducted or results not adequate, justification must be submitted and accepted)

Definitions

Reliability testing applies to both the data elements and computed measure score. Examples of reliability testing for data elements include, but are not limited to: inter-rater/abstractor or intra-rater/abstractor studies; internal consistency for multi-item scales; test-retest for survey items. Reliability testing of the measure score addresses precision of measurement (e.g., signal-to-noise).

Validity testing applies to both the data elements and computed measure score. Validity testing of data elements typically analyzes agreement with another authoritative source of the same information. Examples of validity testing of the measure score include, but are not limited to: testing hypotheses that the measures scores indicate quality of care, e.g., measure scores are different for groups known to have differences in quality assessed by another valid quality measure or method; correlation of measure scores with another valid indicator of quality for the specific topic; or relationship to conceptually related measures (e.g., scores on process measures to scores on outcome measures). Face validity of the measure score as a quality indicator may be adequate if accomplished through a systematic and transparent process, by identified experts, and explicitly addresses whether performance scores resulting from the measure as specified can be used to distinguish good from poor quality. The degree of consensus and any areas of disagreement must be provided/discussed.

Examples of evidence that an exclusion distorts measure results include, but are not limited to: frequency of occurrence, variability of exclusions across providers, and sensitivity analyses with and without the exclusion.

Patient preference is not a clinical exception to eligibility and can be influenced by provider interventions.

Risk factors that influence outcomes should not be specified as exclusions.

With large enough sample sizes, small differences that are statistically significant may or may not be practically or clinically meaningful. The substantive question may be, for example, whether a statistically significant difference of one percentage point in the percentage of patients who received smoking cessation counseling (e.g., 74 percent v. 75 percent) is clinically meaningful; or whether a statistically significant difference of \$25 in cost for an episode of

care (e.g., \$5,000 v.\$5,025) is practically meaningful. Measures with overall less-than-optimal performance may not demonstrate much variability across providers.

Please separate added or updated information from the most recent measure evaluation within each question response in the Scientific Acceptability sections. For example:

Current Submission:

Updated testing information here.

Previous (Year) Submission:

Testing from the previous submission here.

2a.01. Select only the data sources for which the measure is tested.

[Response Begins]

[Response Ends]

2a.02. If an existing dataset was used, identify the specific dataset.

The dataset used for testing must be consistent with the measure specifications for target population and healthcare entities being measured; e.g., Medicare Part A claims, Medicaid claims, other commercial insurance, nursing home MDS, home health OASIS, clinical registry).

[Response Begins]

[Response Ends]

2a.03. Provide the dates of the data used in testing.

Use the following format: "MM-DD-YYYY - MM-DD-YYYY"

[Response Begins]

[Response Ends]

2a.04. Select the levels of analysis for which the measure is tested.

Testing must be provided for all the levels specified and intended for measure implementation, e.g., individual clinician, hospital, health plan.

Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.

Please do not select:

- Clinician: Clinician
- Population: Population

[Response Begins]

[Response Ends]

2a.05. List the measured entities included in the testing and analysis (by level of analysis and data source).

Identify the number and descriptive characteristics of measured entities included in the analysis (e.g., size, location, type); if a sample was used, describe how entities were selected for inclusion in the sample.

[Response Begins]

[Response Ends]

2a.06. Identify the number and descriptive characteristics of patients included in the analysis (e.g., age, sex, race, diagnosis), separated by level of analysis and data source; if a sample was used, describe how patients were selected for inclusion in the sample.

If there is a minimum case count used for testing, that minimum must be reflected in the specifications.

[Response Begins]

[Response Ends]

2a.07. If there are differences in the data or sample used for different aspects of testing (e.g., reliability, validity, exclusions, risk adjustment), identify how the data or sample are different for each aspect of testing.

[Response Begins]

[Response Ends]

2a.08. List the social risk factors that were available and analyzed.

For example, patient-reported data (e.g., income, education, language), proxy variables when social risk data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate) which do not have to be a proxy for patient-level data.

[Response Begins]

[Response Ends]

Note: If accuracy/correctness (validity) of data elements was empirically tested, separate reliability testing of data elements is not required – in 2a.09 check patient or encounter-level data; in 2a.010 enter “see validity testing section of data elements”; and enter “N/A” for 2a.11 and 2a.12.

2a.09. Select the level of reliability testing conducted.

Choose one or both levels.

[Response Begins]

[Response Ends]

2a.10. For each level of reliability testing checked above, describe the method of reliability testing and what it tests.

Describe the steps—do not just name a method; what type of error does it test; what statistical analysis was used.

[Response Begins]

[Response Ends]

2a.11. For each level of reliability testing checked above, what were the statistical results from reliability testing?

For example, provide the percent agreement and kappa for the critical data elements, or distribution of reliability statistics from a signal-to-noise analysis. For score-level reliability testing, when using a signal-to-noise analysis, more than just one overall statistic should be reported (i.e., to demonstrate variation in reliability across providers). If a particular method yields only one statistic, this should be explained. In addition, reporting of results stratified by sample size is preferred (pg. 18, [NQF Measure Evaluation Criteria](#)).

[Response Begins]

[Response Ends]

2a.12. Interpret the results, in terms of how they demonstrate reliability.

(In other words, what do the results mean and what are the norms for the test conducted?)

[Response Begins]

[Response Ends]

2b.01. Select the level of validity testing that was conducted.

[Response Begins]

[Response Ends]

2b.02. For each level of testing checked above, describe the method of validity testing and what it tests.

Describe the steps—do not just name a method; what was tested, e.g., accuracy of data elements compared to authoritative source, relationship to another measure as expected; what statistical analysis was used.

[Response Begins]

[Response Ends]

2b.03. Provide the statistical results from validity testing.

Examples may include correlations or t-test results.

[Response Begins]

[Response Ends]

2b.04. Provide your interpretation of the results in terms of demonstrating validity. (i.e., what do the results mean and what are the norms for the test conducted?)

[Response Begins]

[Response Ends]

2b.05. Describe the method for determining if statistically significant and clinically/practically meaningful differences in performance measure scores among the measured entities can be identified.

Describe the steps—do not just name a method; what statistical analysis was used? Do not just repeat the information provided in Importance to Measure and Report: Gap in Care/Disparities.

[Response Begins]

[Response Ends]

2b.06. Describe the statistical results from testing the ability to identify statistically significant and/or clinically/practically meaningful differences in performance measure scores across measured entities.

Examples may include number and percentage of entities with scores that were statistically significantly different from mean or some benchmark, different from expected; how was meaningful difference defined.

[Response Begins]

[Response Ends]

2b.07. Provide your interpretation of the results in terms of demonstrating the ability to identify statistically significant and/or clinically/practically meaningful differences in performance across measured entities.

In other words, what do the results mean in terms of statistical and meaningful differences?

[Response Begins]

[Response Ends]

2b.08. Describe the method of testing conducted to identify the extent and distribution of missing data (or non-response) and demonstrate that performance results are not biased due to systematic missing data (or differences between responders and non-responders). Include how the specified handling of missing data minimizes bias.

Describe the steps—do not just name a method; what statistical analysis was used.

[Response Begins]

[Response Ends]

2b.09. Provide the overall frequency of missing data, the distribution of missing data across providers, and the results from testing related to missing data.

For example, provide results of sensitivity analysis of the effect of various rules for missing data/non-response. If no empirical sensitivity analysis was conducted, identify the approaches for handling missing data that were considered and benefits and drawbacks of each).

[Response Begins]

[Response Ends]

2b.10. Provide your interpretation of the results, in terms of demonstrating that performance results are not biased due to systematic missing data (or differences between responders and non-responders), and how the specified handling of missing data minimizes bias.

In other words, what do the results mean in terms of supporting the selected approach for missing data and what are the norms for the test conducted; if no empirical analysis was conducted, justify the selected approach for missing data.

[Response Begins]

[Response Ends]

Note: This item is directed to measures that are risk-adjusted (with or without social risk factors) OR to measures with more than one set of specifications/instructions (e.g., one set of specifications for how to identify and compute the measure from medical record abstraction and a different set of specifications for claims or eQMs). It does not apply to measures that use more than one source of data in one set of specifications/instructions (e.g., claims data to identify the denominator and medical record abstraction for the numerator). Comparability is not required when comparing performance scores with and without social risk factors in the risk adjustment model. However, if comparability is not demonstrated for measures with more than one set of specifications/instructions, the different specifications (e.g., for medical records vs. claims) should be submitted as separate measures.

2b.11. Indicate whether there is more than one set of specifications for this measure.

[Response Begins]

[Response Ends]

2b.12. Describe the method of testing conducted to compare performance scores for the same entities across the different data sources/specifications.

Describe the steps—do not just name a method. Indicate what statistical analysis was used.

[Response Begins]

[Response Ends]

2b.13. Provide the statistical results from testing comparability of performance scores for the same entities when using different data sources/specifications.

Examples may include correlation, and/or rank order.

[Response Begins]

[Response Ends]

2b.14. Provide your interpretation of the results in terms of the differences in performance measure scores for the same entities across the different data sources/specifications.

In other words, what do the results mean and what are the norms for the test conducted.

[Response Begins]

[Response Ends]

2b.15. Indicate whether the measure uses exclusions.

[Response Begins]

[Response Ends]

2b.16. Describe the method of testing exclusions and what was tested.

Describe the steps—do not just name a method; what was tested, e.g., whether exclusions affect overall performance scores; what statistical analysis was used?

[Response Begins]

[Response Ends]

2b.17. Provide the statistical results from testing exclusions.

Include overall number and percentage of individuals excluded, frequency distribution of exclusions across measured entities, and impact on performance measure scores.

[Response Begins]

[Response Ends]

2b.18. Provide your interpretation of the results, in terms of demonstrating that exclusions are needed to prevent unfair distortion of performance results.

In other words, the value outweighs the burden of increased data collection and analysis. Note: If patient preference is an exclusion, the measure must be specified so that the effect on the performance score is transparent, e.g., scores with and without exclusion.

[Response Begins]

[Response Ends]

2b.19. Check all methods used to address risk factors.

[Response Begins]

[Response Ends]

2b.20. If using statistical risk models, provide detailed risk model specifications, including the risk model method, risk factors, risk factor data sources, coefficients, equations, codes with descriptors, and definitions.

[Response Begins]

[Response Ends]

2b.21. If an outcome or resource use measure is not risk-adjusted or stratified, provide rationale and analyses to demonstrate that controlling for differences in patient characteristics (i.e., case mix) is not needed to achieve fair comparisons across measured entities.

[Response Begins]

[Response Ends]

2b.22. Select all applicable resources and methods used to develop the conceptual model of how social risk impacts this outcome.

[Response Begins]

[Response Ends]

2b.23. Describe the conceptual and statistical methods and criteria used to test and select patient-level risk factors (e.g., clinical factors, social risk factors) used in the statistical risk model or for stratification by risk.

Please be sure to address the following: potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of $p < 0.10$ or other statistical tests; correlation of x or higher. Patient factors should be present at the start of care, if applicable. Also discuss any “ordering” of risk factor inclusion; note whether social risk factors are added after all clinical factors. Discuss any considerations regarding data sources (e.g., availability, specificity).

[Response Begins]

[Response Ends]

2b.24. Detail the statistical results of the analyses used to test and select risk factors for inclusion in or exclusion from the risk model/stratification.

[Response Begins]

[Response Ends]

2b.25. Describe the analyses and interpretation resulting in the decision to select or not select social risk factors.

Examples may include prevalence of the factor across measured entities, availability of the data source, empirical association with the outcome, contribution of unique variation in the outcome, or assessment of between-unit effects and within-unit effects. Also describe the impact of adjusting for risk (or making no adjustment) on providers at high or low extremes of risk.

[Response Begins]

[Response Ends]

2b.26. Describe the method of testing/analysis used to develop and validate the adequacy of the statistical model or stratification approach (describe the steps—do not just name a method; what statistical analysis was used). Provide the statistical results from testing the approach to control for differences in patient characteristics (i.e., case mix) below. If stratified ONLY, enter “N/A” for questions about the statistical risk model discrimination and calibration statistics.

Validation testing should be conducted in a data set that is separate from the one used to develop the model.

[Response Begins]

[Response Ends]

2b.27. Provide risk model discrimination statistics.

For example, provide c-statistics or R-squared values.

[Response Begins]

[Response Ends]

2b.28. Provide the statistical risk model calibration statistics (e.g., Hosmer-Lemeshow statistic).

[Response Begins]

[Response Ends]

2b.29. Provide the risk decile plots or calibration curves used in calibrating the statistical risk model.

The preferred file format is .png, but most image formats are acceptable.

[Response Begins]

[Response Ends]

2b.30. Provide the results of the risk stratification analysis.

[Response Begins]

[Response Ends]

2b.31. Provide your interpretation of the results, in terms of demonstrating adequacy of controlling for differences in patient characteristics (i.e., case mix).

In other words, what do the results mean and what are the norms for the test conducted?

[Response Begins]

[Response Ends]

2b.32. Describe any additional testing conducted to justify the risk adjustment approach used in specifying the measure.

Not required but would provide additional support of adequacy of the risk model, e.g., testing of risk model in another data set; sensitivity analysis for missing data; other methods that were assessed.

[Response Begins]

[Response Ends]

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.

3.01. Check all methods below that are used to generate the data elements needed to compute the measure score.

[Response Begins]

Coded by someone other than person obtaining original information (e.g., DRG, ICD-10 codes on claims)

Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

[Response Ends]

3.02. Detail to what extent the specified data elements are available electronically in defined fields.

In other words, indicate whether data elements that are needed to compute the performance measure score are in defined, computer-readable fields.

[Response Begins]

Some data elements are in defined fields in electronic sources

[Response Ends]

3.03. 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 data elements not from electronic sources.

[Response Begins]

To allow for widespread reporting across health plans and health care practices, this measure is collected through multiple data sources (administrative data, electronic clinical data, paper records, and registry). We anticipate as electronic health records become more widespread the reliance on paper record review will decrease.

[Response Ends]

3.04. Describe any efforts to develop an eCQM.

[Response Begins]

[Response Ends]

3.06. Describe difficulties (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.

[Response Begins]

[Response Ends]

Consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

3.07. Detail 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),

Attach the fee schedule here, if applicable.

[Response Begins]

Broad public use and dissemination of these measures are 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.

[Response Ends]

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.

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making.

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 demonstrating performance improvement.

4a.01. Check all current uses. For each current use checked, please provide:

Name of program and sponsor

URL

Purpose

Geographic area and number and percentage of accountable entities and patients included

Level of measurement and setting

[Response Begins]

Public Reporting

Payment Program

Regulatory and Accreditation Programs

Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

[Response Ends]

4a.02. Check all planned uses.

[Response Begins]

Public reporting

Payment Program

Quality Improvement (internal to the specific organization)

[Response Ends]

4a.03. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing), explain why the measure is not in use.

For example, do policies or actions of the developer/steward or accountable entities restrict access to performance results or block implementation?

[Response Begins]

N/A

[Response Ends]

4a.04. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes: used in any accountability application within 3 years, and publicly reported within 6 years of initial endorsement.

A 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.

[Response Begins]

N/A

[Response Ends]

4a.05. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

Detail how many and which types of measured entities and/or others were included. If only a sample of measured entities were included, describe the full population and how the sample was selected.

[Response Begins]

Health plans that report HEDIS calculate their rates and know their performance when submitting to NCQA. NCQA publicly reports rates across all plans and also creates benchmarks in order to help plans understand how they perform relative to other plans. Public reporting and benchmarking are effective quality improvement methods.

[Response Ends]

4a.06. Describe the process for providing measure results, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

[Response Begins]

NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual HEDIS Update and Best Practices Conference, NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly. NCQA also regularly provides technical assistance on measures through its Policy Clarification Support System, as described in Section 3c.1.

[Response Ends]

4a.07. Summarize the feedback on measure performance and implementation from the measured entities and others. Describe how feedback was obtained.

[Response Begins]

NCQA measures are evaluated regularly using a consensus-based process to consider input from multiple stakeholders, including but not limited to entities being measured. We use several methods to obtain input, including vetting of the measure with several multi-stakeholder advisory panels, public comment posting, and review of questions submitted to the Policy Clarification Support System. This information enables NCQA to comprehensively assess a measure's adherence to the HEDIS Desirable Attributes of Relevance, Scientific Soundness and Feasibility.

[Response Ends]

4a.08. Summarize the feedback obtained from those being measured.

[Response Begins]

Questions received through the Policy Clarification Support system have generally centered around clarification on whether certain notation in medical record documentation is sufficient to meet measure criteria. Other questions have sought clarification about the screening methods that satisfy the measure numerator. During a recent public comment session, a majority of comments from measured entities supported updates to the measure to align with the latest clinical recommendations.

[Response Ends]

4a.09. Summarize the feedback obtained from other users.

[Response Begins]

This measure has been deemed a priority measure by NCQA and other entities, as illustrated by its use in programs such as the Medicare Advantage Star Rating program.

[Response Ends]

4a.10. Describe how the feedback described has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

[Response Begins]

During the measure's last major update, feedback obtained through the mechanisms described in 4a2.2.1 informed how we revised the measure to include new screening methods recommended by the U.S. Preventive Services Task Force and other major clinical guideline organizations.

[Response Ends]

4b.01. You may refer to data provided in Importance to Measure and Report: Gap in Care/Disparities, but do not repeat here. Discuss any progress on improvement (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). If no improvement was demonstrated, provide an explanation. 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.

[Response Begins]

From 2014 to 2016, performance rates for this measure have been generally stable or shown slight improvement. In 2016, commercial plans on average performance rate of 60 percent, and Medicare plans had an average rate of 68 percent. There continues to be significant variation between the 10th and 90th percentiles, suggesting room for improvement. In 2016, commercial plans in the 10th percentile had a rate of 48 percent, compared to 72 percent among plans in the 90th percentile. For Medicare, plans in the 10th percentile had a rate of 51 percent compared to 81 percent among plans in the 90th percentile.

Given the new US Preventive Services Task Force guidelines for colorectal cancer screening and our recent changes to this measure, we may see performance improvement in the coming years. In 2016, two additional screening methods were added to the guideline and measure. The addition of more screening options may help patients feel more comfortable with the screening process, and therefore increase the number of patients who choose to be screened for colorectal cancer.

[Response Ends]

4b.02. Explain any unexpected findings (positive or negative) during implementation of this measure, including unintended impacts on patients.

[Response Begins]

There were no identified unintended consequences for this measure during testing or since implementation.

[Response Ends]

4b.03. Explain any unexpected benefits realized from implementation of this measure.

[Response Begins]

There were no identified unexpected benefits for this measure during testing or since implementation.

[Response Ends]

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.

If you are updating a maintenance measure submission for the first time in MIMS, please note that the previous related and competing data appearing in question 5.03 may need to be entered in to 5.01 and 5.02, if the measures are NQF endorsed. Please review and update questions 5.01, 5.02, and 5.03 accordingly.

5.01. Search and select all NQF-endorsed related measures (conceptually, either same measure focus or target population).

(Can search and select measures.)

[Response Begins]

[Response Ends]

5.02. Search and select all NQF-endorsed competing measures (conceptually, the measures have both the same measure focus or target population).

(Can search and select measures.)

[Response Begins]

[Response Ends]

5.03. If there are related or competing measures to this measure, but they are not NQF-endorsed, please indicate the measure title and steward.

[Response Begins]

Colorectal Cancer Screening – Minnesota Community Measurement

[Response Ends]

5.04. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s), indicate whether the measure specifications are harmonized to the extent possible.

[Response Begins]

Yes

[Response Ends]

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

[Response Begins]

Minnesota Community Measurement: These measures are harmonized but intended for different levels of accountability. --Both measures exclude patients who have had a total colectomy, a history of colorectal cancer, or who have been in hospice care. --Both measures include the same screening methods and intervals. --The Minnesota Community Measurement quality measure is intended for use at the clinician or practice-level, whereas NQF#0034 is intended for use at the health plan level. American Gastroenterological Association: These measures have different areas of focus and are harmonized where appropriate. --The American Gastroenterological Association measure focuses on only one of the available screening methods: colonoscopy. The measure assesses

whether patients who have had a colonoscopy also have a recommended follow-up interval of 10 years documented in their colonoscopy report.

[Response Ends]

5.06. Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality). Alternatively, justify endorsing an additional measure.

Provide analyses when possible.

[Response Begins]

Not applicable.

[Response Ends]

Appendix

Supplemental materials may be provided in an appendix.:

No appendix

Contact Information

Measure Steward (Intellectual Property Owner):

Measure Steward Point of Contact:

Measure Developer if different from Measure Steward:

Measure Developer Point(s) of Contact:

Additional Information

1. Provide any supplemental materials, if needed, as an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be collated one file with a table of contents or bookmarks. If material pertains to a specific criterion, that should be indicated.

[Response Begins]

No appendix

[Response Ends]

2. List the workgroup/panel members' names and organizations.

Describe the members' role in measure development.

[Response Begins]

The NCQA Colorectal Cancer Screening Measurement Advisory Panels advised NCQA during measure development. They evaluated the way staff specified the measure, reviewed field test results, and assessed NCQA's overall desirable attributes of Relevance, Scientific Soundness, and Feasibility. The advisory panel consisted of a balanced group of experts. In addition to this advisory panel, we vetted the measure with a host of other stakeholders, as is our process. Thus, our measures are the result of consensus from a broad and diverse group of stakeholders.

2008 Colorectal Cancer Measurement Advisory Panel members:

Joel V. Brill, Predictive Health, LLC

Durado Brooks, American Cancer Society

Robert Fletcher, Harvard Medical School

William Lawrence, AHRQ Center for Outcomes and Effectiveness

T.R. Levin, Kaiser Permanente

Michael Pignone, UNC Hospital

Evelyn Whitlock

2016 Colorectal Cancer Screening Measurement Advisory Panel members:

Matthew Barish, MD FACR, Stony Brook University Hospital

Linda Berthold, PhD, Central California Alliance for Health

Durado Brooks, MD MPH, American Cancer Society

Joseph Chin, MD MS, Centers for Medicare and Medicaid Services

T.R. Levin, MD, Kaiser Permanente Northern California

Steven Phillips, MD CMD, Sierra Health Services Inc

Tim Wilt, MD MPH, VA Medical Center Minneapolis

Ann Zauber, PhD, Memorial Sloan Kettering Cancer Center

2016 Geriatric Measurement Advisory Panel members:

Wade Aubry, UCSF Institute for Health Policy Studies

Arlene Bierman, AHRQ

Patricia A. Bomba, MD FACP, Excellus BlueCross BlueShield

Jennie Chin Hansen, RN, American Geriatrics Society

Joyce Dubow, Public Member/Consumer Advocate

Peter Hollman, Brown University

Jeffrey Kelman, MMSc, MD, Centers for Medicare & Medicaid Services

Steven Phillips, MD, CMD, Geriatric Specialty Care

Eric G. Tangalos, MD, FACP, AGSF, CMD, Mayo Clinic

Dirk Wales, MD, PsyD, Cigna HealthSpring
Joan Weiss, PhD, RN, CRNP, U.S. Department of Health and Human Services
Neil Wenger, MD, UCLA Division of Medicine

2016 Committee on Performance Measurement members:

Bruce Bagley, MD, American Medical Association
Andrew Baskin, MD, Aetna
Jonathan D. Darer, MD, MPH, Medicalis
Helen Darling, National Quality Forum
Foster Gesten, MD, FACP, New York State Department of Health
Kate Goodrich, MD, MHS, Centers for Medicare and Medicaid Services
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[Response Ends]

3. Indicate the year the measure was first released.

[Response Begins]

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4. Indicate the month and year of the most recent revision.

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5. Indicate the frequency of review, or an update schedule, for this measure.

[Response Begins]

Approximately every 3 years, sooner if the clinical guidelines have changed significantly.

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6. Indicate the next scheduled update or review of this measure.

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