



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 #: 0098

Corresponding Measures:

De.2. Measure Title: Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

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

De.3. Brief Description of Measure: This is a clinical performance measure which assesses whether women age 65+ were provided appropriate treatment for urinary incontinence (UI). This measure has three rates:

(A) Assessment for UI: Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.

(B) Characterization of UI: Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months

(C) Plan of Care for UI: Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months

1b.1. Developer Rationale: The intent of this measure is to evaluate the rate of appropriate screening, characterization and treatment of UI among older women living in the community. The first rate assesses whether a health care provider asked the patient if they experienced any problems with UI. For those women who are identified as having UI, this measure assesses whether the health care provider characterized the UI and provided a plan of care to the patient. The improvement in quality envisioned by use of this measure is increased discussion of UI between patients and health care providers and increased use of appropriate treatment to manage the symptoms of UI. Tracking and reporting the rate of discussing, characterizing and treating UI among older adults will help to identify gaps in care and increase awareness among practitioners and patients. Despite the prevalence of UI and the significant negative impact UI can have on quality of life, there is a stigma associated with the condition. Health care providers need to proactively address UI among their patients and need to be aware of the many treatment options available.

S.4. Numerator Statement: This measure has three rate. The numerator for each of the rates is as follows:

(A)Assessment for UI: Patients who were assessed for the presence or absence of urinary incontinence within 12 months

(B)Characterization of UI: Patients whose urinary incontinence was characterized at least once within 12 months

(C)Plan of Care for UI: Patients with a documented plan of care for urinary incontinence at least once within 12 months

S.7. Denominator Statement: There are two denominators for the rates in this measure.

(A) Assessment of UI: All female patients aged 65 years and older who visited and eligible provider in the measurement year

(B&C) Characterization and Plan of Care for UI: All female patients aged 65 years and older with a diagnosis of urinary incontinence who visited an eligible provider in the measurement year.

S.10. Denominator Exclusions: Documentation of medical reason(s) for not assessing the presence or absence of urinary incontinence within 12 months

De.1. Measure Type: Process

S.23. Data Source: Paper Medical Records

S.26. Level of Analysis: Clinician : Group/Practice, Clinician : Individual
IF Endorsement Maintenance – Original Endorsement Date: May 01, 2007 Most Recent Endorsement Date: May 01, 2007
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?

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. <i>Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.</i>
1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form Evidence_Form_0098.docx
1b. Performance Gap Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating: <ul style="list-style-type: none"> 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) The intent of this measure is to evaluate the rate of appropriate screening, characterization and treatment of UI among older women living in the community. The first rate assesses whether a health care provider asked the patient if they experienced any problems with UI. For those women who are identified as having UI, this measure assesses whether the health care provider characterized the UI and provided a plan of care to the patient. The improvement in quality envisioned by use of this measure is increased discussion of UI between patients and health care providers and increased use of appropriate treatment to manage the symptoms of UI. Tracking and reporting the rate of discussing, characterizing and treating UI among older adults will help to identify gaps in care and increase awareness among practitioners and patients. Despite the prevalence of UI and the significant negative impact UI can have on quality of life, there is a stigma associated with the condition. Health care providers need to proactively address UI among their patients and need to be aware of the many treatment options available. 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. Data are from the Physician Quality Reporting System (PQRS) most recent available data. Rates are averaged at the level of eligible provider. The Percent of eligible providers reporting is the proportion of eligible providers participating in PQRS who chose to report on this quality measure. (A) Assessment of UI YEAR Rate Percent of Eligible Providers Reporting 2007 84.4% 0.5% 2008 75.0% 0.7% 2009 57.3% 1.3% 2010 66.5% 1.3% (B) Characterization of UI YEAR Rate Percent of Eligible Providers Reporting 2007 96.4% 1.4%

2008 | 85.7% | 1.4%
 2009 | 68.9% | 2.0%
 2010 | 82.5% | 2.0%

(C) Plan of Care for UI

YEAR | Rate | Percent of Eligible Providers Reporting

2007 | 94.9% | 1.5%
 2008 | 85.2% | 1.4%
 2009 | 76.4% | 1.8%
 2010 | 82.7% | 2.0%

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.

2010 Physician Quality Reporting System and eRx Experience Report.

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.*

Racial Disparities: This measure is not reported by racial/ethnic subgroup. Studies have shown no significant differences among race associated with reporting of UI with 30.6% of Hispanics reporting UI, 30.3% of African Americans reporting UI, 38.3% of whites reporting UI and 31.6% of Asians reporting (Mardon 2006). A 2011 study examined the prevalence of health care seeking, barriers of care and use of therapeutic modalities among black and white community dwelling black and white women who self-reported for UI. The researchers found that black and white women seek treatment for UI at similar, albeit low, levels. They found no association between perceived barriers and race, nor did they find any association between race and most self-care strategies. Black women were more likely to restrict fluid intake and slightly less likely to perform Kegel exercises (Berger, 2011). Another study did find racial differences between races for remission, admission and frequency of UI, indicating that although common in all races, presentation of UI may vary by race (Townsend, 2011).

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.

Berger MB, Patel DA, Miller JM, Delancey JO, & Fenner DE. Racial Differences in Self-Reported Healthcare Seeking and Treatment for Urinary Incontinence in Community-Dwelling Women From the EPI Study. *Neurourol Urodyn* 2011; 30(8): 1442-7.

Mardon R., Halim S., Pawlson G., and Haffer S. Management of Urinary Incontinence in Medicare Managed Care Beneficiaries. *Arch Internal Med* 2006; 166:1128-1133.

Townsend MK, Curhan GC, Resnick NM, & Grodstein F. Original Research: Rates of Remission, Improvement and Progression of Urinary Incontinence in Asian, Black and White Women. *American Journal of Nursing* 2011; 111(4):26-33.

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, A leading cause of morbidity/mortality, High resource use, 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.

Prevalence of Urinary Incontinence: An estimated 25 million Americans, and 200 million worldwide, suffer from the involuntary leakage of urine—urinary incontinence (UI) (NAFC, 2008). The severity of UI ranges from occasionally leaking urine during a cough or sneeze (stress incontinence) to having an urge to urinate that's so sudden and strong (urge incontinence) there is no time to get to a bathroom (Mayo Clinic, 2011). UI affects between 30 and 60 percent of older women (Markland, 2011).

Impact of UI on Health and Well-Being: Data analysis from the Medicare Health Outcomes Survey (HOS) indicates that compared with 14 other chronic conditions, UI was associated with the lowest mental health related quality of life scores, second only to gastrointestinal disease (Hawkins 2011). In addition, studies have shown a strong, statistically significant positive association between UI symptoms and depressive symptoms ($p < 0.001$), (Coyne 2008). UI is associated with a wide range of morbidity in the elderly, including urinary tract infections (OR 2.90; 95% CI 2.49, 3.37), constipation (OR 1.83; 95% CI 1.49, 2.24), and depression (OR 1.81; 95% CI 1.45, 2.26) (Van Gerwen 2007). UI also has a significant negative effect on the psychological well-being of family caregivers (Fultz 2005).

Financial Impact of UI: Urinary incontinence poses a heavy financial burden. Annual direct cost of treating UI was estimated at \$26.3 billion in 1995 and rose to \$32 billion in 2000 (Wagner, 1998; Levy, 2006). In 2000, the cost incurred by community and institutional residents was \$9.1 and \$3.5 billion, respectively (Hu, 2000). Medicare pays for nearly half of all UI-related medical services with the rest covered by out-of-pocket expenses or other insurance products. UI poses a significant financial burden to the family caregivers who provide support to an individual with UI. One study estimated a national annual cost of more than \$6 billion for incontinence-related informal care (Langa, 2002). While costs incurred from UI are high, the underlying causes of UI can be diagnosed and effectively managed by a practitioner (Tannenbaum, 2001; Lee, 2000). Several simple office visit tests are available to assess UI; cough test, measurement of voided volume, urinalysis, urine culture and measurement of post-void residual volume (Gibbs, 2007).

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

Coyne KS, Sexton CC, Irwin DE, Kopp ZS, Kelleher CJ, Milsom I. The impact of overactive bladder, incontinence and other lower urinary tract symptoms on quality of life, work productivity, sexuality and emotional well-being in men and women: results from the EPIC study. *BJU Int.* 2008; 101(11):1388-95.

Fultz NH, Rahrig Jenkins K, Ostbye T, Taylor DH, Kabeto MU, Langa KM. The impact of own and spouse's urinary incontinence on depressive symptoms. *Soc Sci Med* 2005;60(11): 2537-48.

Gibbs CF., Johson TM., and Ouslander JG. Office management of geriatric urinary incontinence. *Am J Medicine* 2007; 120:211-220.

Hawkins K, Pernarelli J, Ozminkowski RJ. The prevalence of urinary incontinence and its burden on the quality of life among older adults with Medicare supplement insurance. *Qual Life Res* 2011;20:723-32.

Hu TW, Wagner TH, Bentkover JD, Leblanc K, Zhou SZ, Hunt T. Costs of urinary incontinence and overactive bladder in the United States: a comparative study. *Urology.* 2004; 63(3):461-465.

Langa K, Fultz N, Saint S, Kabeto MU, & Herzog AR. Informal Caregiving Time and Costs for Urinary Incontinence in Older Adults in the United States. *JAGS* 2002; 50(4):733-7.

Levy R & Muller N. Urinary Incontinence: Economic Burden and New Choices in Pharmaceutical Treatment. *Advances in Therapy* 2006;23(4):556-73.

Markland AD (2), Vaughan CP, Johnson TM, Burgio KL, & Goode PS. Incontinence. *Medical Clinics of North America* 2011; 95(3):539-54.

Mayo Clinic. (2011). Urinary Incontinence. Accessed June 23, 2012 from: <http://www.mayoclinic.com/health/urinary-incontinence/DS00404>

National Association for Continence (NAFC). Statistics. 2008. Accessed June 23, 2012 from: <http://www.nafc.org/media/statistics/>

Tannenbaum C., Perrin L., DuBeau C.E., Kuchel G.A. Diagnosis and Management of Urinary Incontinence in the Older Patient. *Arch*

Phys Med Rehabil. 2001; 82: 134-138.

Van Gerwen M, Schellevis F, Largo-Jansse T. Comorbidities Associated with Urinary Incontinence: A Case-Control Study from the Second Dutch National Survey of General Practice. Journal of the American Board of Family Medicine. 2007; 20(6): 608-610.

Wagner T.H., Hu T-W. Economic costs of urinary incontinence in 1995. Urology. 1998; 51:355-361.

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.)

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):

Genitourinary (GU), Genitourinary (GU) : Incontinence/pelvic floor disorders

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

Screening

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.)

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/2011-Physician-Quality-Reporting-System-Items/CMS1254515.html>

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)

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)

NoAttachment Attachment:

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

MEASURES COMBINED

Three measures with previous endorsement (98, 99, and 100) have been combined into this single measure. This was done to highlight that all three measures should be used as a set.

CPT II CODES REMOVED

Original testing on these measures was done in medical records to ensure the measures could be reliably and feasibly abstracted from medical records. After testing was completed, CPT II codes were designed to ease reporting of the measures in the PQRI/PQRS program. The previous endorsed versions of these measures list these CPT II codes in the numerator detail. Recently, NQF has clarified that only codes which have been tested for reliability should be included in the NQF measure specification. Because the CPT II codes for this measure have not been tested for reliability we have removed the codes from the NQF submission.

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.

This measure has three rate. The numerator for each of the rates is as follows:

(A)Assessment for UI: Patients who were assessed for the presence or absence of urinary incontinence within 12 months

(B)Characterization of UI: Patients whose urinary incontinence was characterized at least once within 12 months

(C)Plan of Care for UI: Patients with a documented plan of care for urinary incontinence at least once within 12 months

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.)

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.

The following definitions are used in the numerator for all three rates:

Urinary incontinence is defined as any involuntary leakage of urine.

Assessment for UI is defined as documentation of either the presence or absence of involuntary leakage of urine.

Characterization of urinary incontinence may include one or more the following: frequency, volume, timing, type of symptoms, and/or how bothersome to the patient

Plan of care may include behavioral interventions (e.g., bladder training, pelvic floor muscle training, prompted voiding), referral to specialist, surgical treatment, reassess at follow-up visit, lifestyle interventions, addressing co-morbid factors, modification or discontinuation of medications contributing to urinary incontinence, or pharmacologic therapy.

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

There are two denominators for the rates in this measure.

(A) Assessment of UI: All female patients aged 65 years and older who visited and eligible provider in the measurement year

(B&C) Characterization and Plan of Care for UI: All female patients aged 65 years and older with a diagnosis of urinary incontinence who visited an eligible provider in the measurement year.

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

Elderly

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)

The denominator for rate (A) Assessment of UI, is based on office visits to an eligible provider. CPT codes are used to identify female patients age 65 + with an office visit to an eligible provider.

The denominator for rates (B&C) Characterization and Plan of Care for UI, is based on office visits and a documented diagnosis using ICD-9 codes.

(A) Assessment of UI:

CPT codes:

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404

(B&C) Characterization & Plan of Care:

ICD-9 diagnosis codes

307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39

AND

CPT service codes

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404

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

Documentation of medical reason(s) for not assessing the presence or absence of urinary incontinence within 12 months

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)*

Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence within 12 months.

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)*

N/A

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.

NoAttachment

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

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.)

(A) Assessment for UI

1. Identify eligible population: All female patients aged 65 years and older identified through CPT services codes for an ambulatory care office visit.
2. Identify numerator: Identify patients in eligible population who have documentation of being assessed for urinary incontinence.
3. Identify exclusions: Identify patients in eligible population with documented medical reason(s) for not assessing the presences or absence of urinary incontinence.
4. Calculate Rate: Step 2/(Step 1-Step 3)

(B) Characterize UI

1. Identify eligible population: All female patients aged 65 years and older identified through CPT services codes for an ambulatory care office visit.
2. Identify denominator: Identify eligible population with diagnosis of Urinary Incontinence (through ICD-9 codes)
3. Identify numerator: Identify denominator patients who have documentation of having their UI characterized.
4. Calculate Rate: Step 3/Step 2

(C) Plan of Care for UI

1. Identify eligible population: All female patients aged 65 years and older identified through CPT services codes for an ambulatory care office visit.
2. Identify denominator: Identify eligible population with diagnosis of Urinary Incontinence (through ICD-9 codes)
3. Identify numerator: Identify denominator patients who have documentation of a plan of care for UI.
4. Calculate Rate: Step 3/Step 2

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)
NoAttachment

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.

No sampling.

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.

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

If other, please describe in S.24.

Paper Medical Records

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.

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)

NoAttachment

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

Clinician : Group/Practice, Clinician : Individual

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.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

0098_UI_Measure_Testing_Form_updated4102013.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.

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

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)

Some data elements are in defined fields in electronic sources

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.

Two of the rates in this measure were selected for e-specification under a contract for use in Meaningful Use Stage 2 (assessment of UI and characterization of UI). However e-specifications for these measures were not finalized because the measure was dropped from the final rule for meaningful use. NCQA and AMA are open to completing the e-specifications for all three rates in this measure when funding is made available to do so.

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.

The specific costs for implementing or using this measure have not been measured, however the successful use in a national reporting program (PQRS) support the feasibility and utility of the measure concept.

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).

None.

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)
	<p>Public Reporting http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/2010-Physician-Quality-Reporting-System.html</p> <p>Payment Program http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html</p> <p>Professional Certification or Recognition Program http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Maintenance_of_Certification_Program_Incentive.html</p>

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

NAME OF PROGRAM: Physician Quality Reporting System

SPONSOR: Centers for Medicare and Medicaid Services (CMS)

PURPOSE: "The Physician Quality Reporting System (Physician Quality Reporting or PQRS) is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals. The program provides an incentive payment to practices with eligible professionals (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Beginning in 2015, the program also applies a payment adjustment to eligible professionals who do not satisfactorily report data on quality measures for covered professional services." CMS Website available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>

GEOGRAPHIC AREA AND NUMBER OF ACCOUNTABLE ENTITIES: This program covers all 50 states in the U.S. In 2010 19,232 practices qualified for an incentive.

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

SOURCE OF DATA: PQRS program.

GEOGRAPHIC AREA: Nationally representative

NUMBER AND PERCENTAGE OF ACCOUNTABLE ENTITIES: Providers who choose to participate in the PQRS program decide which measures they would like to report on based on their practice goals and patient population. Data below show the number of eligible providers for each measure, the number of reporting providers and the % of eligible providers who chose to report on this measure. These numbers are shown for the past two years of available data for each rate.

(A) Assessment of UI

Year | N Eligible Providers | N Reporting Providers | % Reporting Providers

2009 | 527,926 | 6,863 | 1.30%

2010 | 539,520 | 7,014 | 1.30%

(B) Characterization of UI

Year | N Eligible Providers | N Reporting Providers | % Reporting Providers

2009 | 125,467 | 2,509 | 2.00%

2010 | 125,304 | 2,506 | 2.00%

(C) Plan of Care for UI

Year | N Eligible Providers | N Reporting Providers | % Reporting Providers

2009 | 125,346 | 2,256 | 1.80%

2010 | 125,324 | 2,506 | 2.00%

PROGRESS (PERFORMANCE DATA OVER TIME): The data below show improved performance (higher quality care) from 2009 to 2010 for all three rates in this measure.

(A) Assessment of UI

YEAR | Rate

2009 | 57.3%

2010 | 66.5%

(B) Characterization of UI

YEAR | Rate
2009 | 68.9%
2010 | 82.5%

(C) Plan of Care for UI

YEAR | Rate
2009 | 76.4%
2010 | 82.7%

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.

Improvement demonstrated in trends.

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.

No negative consequences to individuals or populations were identified during testing or through subsequent implementation of the measure.

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.

Yes

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

0030 : Management of Urinary Incontinence in Older Adults (MUI)

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.

See 5b.1. for answer.

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.)

Measure 0098 assesses whether there is documentation in the medical record that older women were assessed for UI, and whether there is documentation in the medical record that those women identified as having UI had their UI characterized and were provided a plan of care to manage their UI.

Measure 0030 uses patient reported information to determine if patients in a health plan received UI processes of care (discuss and treatment).

HARMONIZED MEASURE ELEMENTS:

UI is defined in both measures as involuntary or accidental leakage of urine. Treatment options for UI across both measures is defined as any of the following: bladder training, pelvic floor muscle training (exercises), surgical treatment (surgery), pharmacologic therapy (medication).

UNHARMONIZED MEASURE ELEMENTS:

Data Source: Measure 0098 is collected through medical record abstraction. Measure 0030 is collected through a patient survey.

Level of Accountability: Measure 0098 is a physician level measure and therefore only includes patients who had an office visit with an eligible provider. Measure 0030 is a health plan level measure and therefore include the entire health plan population.

Population: Measure 0098 focuses exclusively on women, whereas 0030 refers to all patients. Since women are more likely to experience UI, 0098 was developed to specifically target the care provided to women. The panel of experts who developed 0098 felt the benefits of measurement would be highest for women.

Treatment options: There are two treatment options which are specific to measure 0098 which are not included in 0030 because they refer to a transfer of care to another provider or point in time: referral to specialist and reassess at follow-up visit. These concepts were not easily captured in an annual patient survey. There are several treatment options of UI which are included in measures 0098 which are not included in 0030 because they could not be described in a way which was easy for patients to recall and self-report (i.e. prompted voiding, lifestyle interventions, addressing co-morbid factors, modification or discontinuation of medications contributing to urinary incontinence.)

Measure concept C2050 is focused on a more narrow denominator(Female patients who had SUI surgery). The numerators for these measures are similar and includes many of the same treatment options, surgery, biofeedback, fluid restriction, pelvic floor muscle exercises, and timed voiding.

Although 0030 and 0098 have the same measure focus and same target population they are not considered competing measures because they are specified for different levels of analysis and use different data sources (see recent presentation by NQF on measure harmonization).

The two measure provide complementary data. Measure 0098 does not have the limitations of recall bias that 0030 is subject to. Measure 0098 also provides more detail about the processes of care provided (assessment, characterization and plan of care documentation). Measure 0030 is more patient centered and reflects the experiences of the patient as opposed to the provider documentation. Measure 0030 may be less resource intensive (a survey of patients can often be less costly than medical record abstraction). Measure 0030 is a health plan level measure and therefore can include a larger denominator which is more representative of the population and include care that is provided outside the physician office setting.

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.

Attachment **Attachment:** [NQF_GI_GUPProject_Stage2_Checklist_Memo_NCQA_Response-634935115464929631.docx](#)

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Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance

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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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#0098 Urinary Incontinence: Assessment, Characterization, and Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older, Last Updated: Jan 22, 2014

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 Patricia Sokol- American Medical Association
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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2008

Ad.3 Month and Year of most recent revision:

Ad.4 What is your frequency for review/update of this measure?

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

Ad.6 Copyright statement: © 2012 by the National Committee for Quality Assurance

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Ad.7 Disclaimers: N/A

Ad.8 Additional Information/Comments: