



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 #: 0102

Corresponding Measures:

De.2. Measure Title: COPD: inhaled bronchodilator therapy

Co.1.1. Measure Steward: American Thoracic Society

De.3. Brief Description of Measure: Percentage of patients aged 18 years or older, with a diagnosis of COPD (FEV1/FVC < 70%) who have an FEV1 < 60% predicted and have symptoms who were prescribed an inhaled bronchodilator

1b.1. Developer Rationale: Despite major efforts to broadly disseminate the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines and use of COPD performance measures across different specialty societies, management of COPD, and specifically prescription for long-acting inhaled bronchodilators, remains suboptimal. Studies show a wide range of deficiencies in adherence to guidelines regarding long-acting inhaled bronchodilator use across different settings (Asche et al., 2012; CDC, 2012; Fitch, et al., 2011; Nantsupawat et al., 2012; Perez et al., 2011; Sharif, et al., 2013). Underuse of bronchodilators were found related to hospital readmissions and to increased total costs of services when compared to patient care adhering to GOLD guidelines (Asche et al., 2012; Nantsupawat et al., 2012).

Suboptimal COPD management has implications for severity of illness, disease progression, patient quality of life and health status, exacerbations (and associated costs) and mortality. Improved adherence to COPD management guidelines, specifically appropriate use of long-acting inhaled bronchodilators, has the potential to improve clinical outcomes and cost of care related to COPD. As a result, we believe this measure will continue to increase appropriate long-acting inhaled bronchodilator use, improving patient management and total costs of COPD.

Citations:

Asche CV, Leader S, Plauschinat C, Raparla S, Yan M, Ye X, Young D. Adherence to current guidelines for chronic obstructive pulmonary disease (COPD) among patients treated with combination of long-acting bronchodilators or inhaled corticosteroids. *Int J Chron Obstruct Pulmon Dis.* 2012;7:201-9.

Centers for Disease Control and Prevention (CDC). Chronic obstructive pulmonary disease and associated health-care resource use - North Carolina, 2007 and 2009. *MMWR Morb Mortal Wkly Rep.* 2012 Mar 2;61(8):143-6.

Fitch K, Iwasaki K, Pvenon B, Plauschinat C, Zhang J. Variation in adherence with Global Initiative for Chronic Obstructive Lung Disease (GOLD) drug therapy guidelines: a retrospective actuarial claims data analysis. *Curr Med Res Opin.* 2011 Jul;27(7):1425-9.

Nantsupawat T, Limsuwat C, Nugent K. Factors affecting chronic obstructive pulmonary disease early rehospitalization. *Chron Respir Dis.* 2012 May;9(2):93-8.

Perez X, Wisnivesky JP, Lurslurchachai L, Kleinman LC, Kronish IM. Barriers to adherence to COPD guidelines among primary care providers. *Respir Med.* 2012 Mar;106(3):374-81.

Sharif R, Cuevas CR, Wang Y, Arora M, Sharma G. Guideline adherence in management of stable chronic obstructive pulmonary disease. *Respir Med.* 2013 Jul;107(7):1046-52.

S.4. Numerator Statement: Patients who were prescribed an inhaled bronchodilator

S.6. Denominator Statement: All patients aged 18 years and older with a diagnosis of COPD, who have FEV1/FVC < 70%, FEV1 <60% predicted and have symptoms (eg, dyspnea, cough/sputum, wheezing)

S.8. Denominator Exclusions: ATS continues to use the PCPI exception methodology that uses three categories of exception reasons for which a patient may be removed from the denominator of an individual measure: medical, patient and system reasons.

Exceptions are used to remove patients from the denominator of a performance measure when a patient does not receive a therapy or service AND that therapy or service would not be appropriate due to specific reasons; otherwise, the patient would meet the denominator criteria. Exceptions are not absolute, and the application of exceptions is based on clinical judgment, individual patient characteristics, or patient preferences. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions include medical reason(s), patient reason(s) or system reason(s) for not prescribing inhaled bronchodilators. Although this methodology does not require the external reporting of more detailed exception data, the ATS recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness.

De.1. Measure Type: Process

S.17. Data Source: Claims, Registry Data

S.20. Level of Analysis: Clinician : Group/Practice

IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Aug 03, 2016

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

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

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

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

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

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

[0102_Evidence_2015_amended_011316.doc](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

No

1b. Performance Gap

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

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

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

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Despite major efforts to broadly disseminate the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines and use of COPD performance measures across different specialty societies, management of COPD, and specifically prescription for long-acting inhaled bronchodilators, remains suboptimal. Studies show a wide range of deficiencies in adherence to guidelines regarding long-acting inhaled bronchodilator use across different settings (Asche et al., 2012; CDC, 2012; Fitch, et al., 2011; Nantsupawat et al.,

2012; Perez et al., 2011; Sharif, et al., 2013). Underuse of bronchodilators were found related to hospital readmissions and to increased total costs of services when compared to patient care adhering to GOLD guidelines (Asche et al., 2012; Nantsupawat et al., 2012).

Suboptimal COPD management has implications for severity of illness, disease progression, patient quality of life and health status, exacerbations (and associated costs) and mortality. Improved adherence to COPD management guidelines, specifically appropriate use of long-acting inhaled bronchodilators, has the potential to improve clinical outcomes and cost of care related to COPD. As a result, we believe this measure will continue to increase appropriate long-acting inhaled bronchodilator use, improving patient management and total costs of COPD.

Citations:

Asche CV, Leader S, Plauschinat C, Raparla S, Yan M, Ye X, Young D. Adherence to current guidelines for chronic obstructive pulmonary disease (COPD) among patients treated with combination of long-acting bronchodilators or inhaled corticosteroids. *Int J Chron Obstruct Pulmon Dis.* 2012;7:201-9.

Centers for Disease Control and Prevention (CDC). Chronic obstructive pulmonary disease and associated health-care resource use - North Carolina, 2007 and 2009. *MMWR Morb Mortal Wkly Rep.* 2012 Mar 2;61(8):143-6.

Fitch K, Iwasaki K, Pvenson B, Plauschinat C, Zhang J. Variation in adherence with Global Initiative for Chronic Obstructive Lung Disease (GOLD) drug therapy guidelines: a retrospective actuarial claims data analysis. *Curr Med Res Opin.* 2011 Jul;27(7):1425-9.

Nantsupawat T, Limsuwat C, Nugent K. Factors affecting chronic obstructive pulmonary disease early rehospitalization. *Chron Respir Dis.* 2012 May;9(2):93-8.

Perez X, Wisnivesky JP, Lurslurchachai L, Kleinman LC, Kronish IM. Barriers to adherence to COPD guidelines among primary care providers. *Respir Med.* 2012 Mar;106(3):374-81.

Sharif R, Cuevas CR, Wang Y, Arora M, Sharma G. Guideline adherence in management of stable chronic obstructive pulmonary disease. *Respir Med.* 2013 Jul;107(7):1046-52.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. 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 include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

According to a study analyzing the quality of health care in the United States, on average, patients with COPD received the recommended care at an aggregate rate (based on 20 quality indicators) of 58 percent (McGlynn et al., 2003).

The Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines recommend inhaled bronchodilators as a cornerstone of COPD symptom management; however, PCPs often turn to other agents as first-line COPD therapy (Barr et al, 2005; Foster et al, 2007).

A cross-sectional study implemented in July 2008 was designed to assess attitudes and barriers to COPD guideline usage. Five hundred U.S. PCPs (309 family medicine physicians, 191 internists) were included in the analysis. 78.4% of PCPs agreed that a long-acting bronchodilator (LABD) should be added for patients with stage 2–3 COPD whose dyspnea during daily activities is not relieved with an as-needed short-acting bronchodilator. However, only 25.8% of the PCPs “nearly always” recommend using an LABD daily for patients with COPD and mild exertional dyspnea (Salinas et al, 2011).

In a recent study of general medicine practices, 154 clinicians completed a survey to identify barriers to implementing seven recommendations from the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines. Adherence was only 54% to prescribing long-acting bronchodilators when FEV(1) <80% predicted (Perez, et al, 2011).

Another study of 615 patients being treated for COPD by a general practitioner, less than half the patients in all groups used short-

acting bronchodilators. Prescribing long-acting bronchodilators or inhaled corticosteroids conformed to GOLD guidelines in two-thirds of patients with GOLD stage III or IV disease, and approximately half of the less severe patients (Jochmann et al, 2010).

CMS Physician Quality Reporting Initiative/System:

This measure was used in the CMS Physician Quality Reporting Initiative/System (PQRI/S) in the: 2007 through 2011 claims option; 2009 through 2011 registry option; and the 2011 group practice reporting II option.

There is a gap in care as shown by this 2008 data; 53.61% of patients reported on did not meet the measure.(1)

10th percentile: 0.00%
25th percentile: 1.75%
50th percentile: 30.77%
75th percentile: 74.07%
90th percentile: 89.44%

Exception rate: 9.98% This measure has been in use by the CMS Physician Quality Reporting Initiative/System (PQRI/S) since 2007 with the following reporting options:

- 2007 – Claims option
- 2008-2010, 2013 – Claims and registry options
- 2011 – Claims, registry and GPRO II options
- 2012 – Claims, registry, GPRO II and ACO options

Average performance rate:

2010 - 89.7%
2011 - 73.4%
2012 - 98.5%
2013 - 97.0%
2014 - 95.9%

Data from CMS (1) indicates a favorable overall trend 2010-2014. Most recent data indicate a 4% gap in care for 2014. This gap is not aligned with research findings cited in 1b.3.

(1) Source: Timothy Jackson, CMS.

Performance scores from 2012 comprehensive review submitted by PCPI to provide history.

CMS Physician Quality Reporting Initiative/System:

This measure was used in the CMS Physician Quality Reporting Initiative/System (PQRI/S) in the: 2007 through 2011 claims option; 2009 through 2011 registry option; and the 2011 group practice reporting II option.

There is a gap in care as shown by this 2008 data; 53.61% of patients reported on did not meet the measure.(1)

10th percentile: 0.00%
25th percentile: 1.75%
50th percentile: 30.77%
75th percentile: 74.07%
90th percentile: 89.44%

Exception rate: 9.98%

(1) Confidential CMS PQRI Performance Information by Measure. Jan-Sept TAP file.

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.

Studies consistently show suboptimal adherence to guidelines specifically to prescribing inhaled bronchodilator. A retrospective study of 364 patients at Geisinger Health Plan showed adherence to guidelines for bronchodilators ranged from 35%-46% (Asche et al., 2012). A multiyear survey completed by the North Carolina state health department (in collaboration with CDC) found only 48.1% of the 2,187 persons with COPD reported daily use of COPD medication (CDC, 2012). A study of 450 COPD patients conducted at an academic medical center showed 54.7% received treatment according to guidelines (Sharif, et al., 2013). A study of 81 patients hospitalized for COPD exacerbations found 32% were discharged without prescribed long-acting bronchodilators and/or inhaled corticosteroids (Nantsupawat et al., 2012).

A large, retrospective actuarial claims data analysis of 44,366 cases showed “claims for short acting bronchodilator therapy without concomitant use of long acting bronchodilators were identified for 20% of moderate, 14% of severe and 8% of very severe COPD patients; and claims for single long acting bronchodilator therapy in combination with inhaled corticosteroid therapy were identified for 12% of moderate, 19% of severe and 2% of very severe COPD patients” (Fitch, et al., 2011). A survey of 154 clinicians found prescription of inhaled bronchodilators according to guidelines was 54% when FEV1 <80% predicted (Perez et al., 2011).

Citations:

Asche CV, Leader S, Plauschinat C, Raparla S, Yan M, Ye X, Young D. Adherence to current guidelines for chronic obstructive pulmonary disease (COPD) among patients treated with combination of long-acting bronchodilators or inhaled corticosteroids. Int J Chron Obstruct Pulmon Dis. 2012;7:201-9.

Centers for Disease Control and Prevention (CDC). Chronic obstructive pulmonary disease and associated health-care resource use - North Carolina, 2007 and 2009. MMWR Morb Mortal Wkly Rep. 2012 Mar 2;61(8):143-6.

Fitch K, Iwasaki K, Pvenso B, Plauschinat C, Zhang J. Variation in adherence with Global Initiative for Chronic Obstructive Lung Disease (GOLD) drug therapy guidelines: a retrospective actuarial claims data analysis. Curr Med Res Opin. 2011 Jul;27(7):1425-9.

Nantsupawat T, Limswat C, Nugent K. Factors affecting chronic obstructive pulmonary disease early rehospitalization. Chron Respir Dis. 2012 May;9(2):93-8.

Perez X, Wisnivesky JP, Lurslurchachai L, Kleinman LC, Kronish IM. Barriers to adherence to COPD guidelines among primary care providers. Respir Med. 2012 Mar;106(3):374-81.

Sharif R, Cuevas CR, Wang Y, Arora M, Sharma G. Guideline adherence in management of stable chronic obstructive pulmonary disease. Respir Med. 2013 Jul;107(7):1046-52.

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 maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) 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 (4b1) under Usability and Use.

We are not aware of any disparities data from this measure as specified. Please see 1b.5 for a summary of our findings in the literature regarding disparities.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, 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 1b.4

Studies have been done to show associations between education level and income and outcomes related to COPD (Eisner et al., 2011; Holt et al., 2011). Studies also show association between gender and race on the incidence/severity of COPD (Bruse et al., 2011; Diaz et al., 2014; Foreman et al., 2011; Han et al., 2011). However, we found limited research regarding potential disparities on inhaled bronchodilator use in the US.

One cross-sectional study conducted in the UK examined differences in COPD management in three multiethnic, socially deprived communities. Black patients with COPD were less likely to have dyspnea, less likely to be prescribed inhaled bronchodilators and less likely to be referred to pulmonary rehabilitation programs. This group was also more likely to be hospitalized for respiratory conditions on one of the three communities. South Asians were also less likely to have dyspnea and be referred for pulmonary rehabilitation. However, they received medication similar to the white population and had similar hospitalization rates. These differences in medication use are not likely attributable to access or insurance as all patients were covered by the National Health Service (Martin et al., 2012).

One study on adherence to COPD guidelines conducted at an urban academic center in Texas found no association between age, sex, and race and guideline adherence (Sharif, et al., 2013).

The ATS is aware of health disparities related to respiratory diseases and has recently created a Health Equality Subcommittee of the Health Policy Committee. This group has been tasked with providing recommendations for moving toward respiratory health equality to include improving environmental factors, healthy lifestyle promotion, high quality healthcare (prevention, screening, diagnosis and treatment) and further research (Celedón et al., 2014).

Citations:

Bruse S, Sood A, Petersen H, Liu Y, Leng S, Celedón JC, Gilliland F, Celli B, Belinsky SA, Tesfaigzi Y. New Mexican Hispanic smokers have lower odds of chronic obstructive pulmonary disease and less decline in lung function than non-Hispanic whites. *Am J Respir Crit Care Med*. 2011 Dec 1;184(11):1254-60.

Celedón JC, Roman J, Schraufnagel DE, Thomas A, Samet J. Respiratory health equality in the United States. The American thoracic society perspective. *Ann Am Thorac Soc*. 2014 May;11(4):473-9.

Diaz AA, Come CE, Mannino DM, Pinto-Plata V, Divo MJ, Bigelow C, Celli B, Washko GR. Obstructive lung disease in Mexican Americans and non-Hispanic whites: an analysis of diagnosis and survival in the National Health and Nutritional Examination Survey III Follow-up Study. *Chest*. 2014 Feb;145(2):282-9.

Eisner MD, Blanc PD, Omachi TA, Yelin EH, Sidney S, Katz PP, Ackerson LM, Sanchez G, Tolstykh I, Iribarren C. Socioeconomic status, race and COPD health outcomes. *J Epidemiol Community Health* 2011;65:26–34.

Foreman MG, Zhang L, Murphy J, Hansel NN, Make B, Hokanson JE, et al. Early-onset chronic obstructive pulmonary disease is associated with female sex, maternal factors, and African American race in the COPDGene Study. *Am J Respir Crit Care Med*. 2011 Aug 15;184(4):414-20.

Han MK, Curran-Everett D, Dransfield MT, Criner GJ, Zhang L, Murphy JR, Hansel NN, DeMeo DL, Hanania NA, Regan EA, Make BJ, Martinez FJ, Westney GE, Foreman MG; COPDGene Investigators. Racial differences in quality of life in patients with COPD. *Chest*. 2011 Nov;140(5):1169-76.

Holt JB, Zhang X, Presley-Cantrell L, Croft JB. Geographic disparities in chronic obstructive pulmonary disease (COPD) hospitalization among Medicare beneficiaries in the United States. *Int J Chron Obstruct Pulmon Dis*. 2011; 6 321–328.

Martin A, Badrick E, Mathur R, Hull S. Effect of ethnicity on prevalence, severity, and management of COPD in general practice. *Br J Gen Pract*. 2012 Feb;62(595):e76-81.

Sharif R, Cuevas CR, Wang Y, Arora M, Sharma G. Guideline adherence in management of stable chronic obstructive pulmonary disease. *Respir Med*. 2013 Jul;107(7):1046-52.

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 sub criteria 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):

Respiratory, Respiratory : Chronic Obstructive Pulmonary Disease (COPD)

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

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

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.)

The specifications are included in this form.

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

This is not an eMeasure Attachment:

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

No data dictionary Attachment:

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

Yes

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

This measure includes edits to correct a prior transcription error.

The incorrect denominator was: ...with a diagnosis of COPD and who have an FEV1/FVC less than 60%...

The corrected denominator is: ...with a diagnosis of COPD (FEV1/FVC < 70%) who have an FEV1 less than 60% predicted...

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) DO NOT include the rationale for the

measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Patients who were prescribed an inhaled bronchodilator

S.5. 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, 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 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 (S.14).

Definition:

Prescribed – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

NUMERATOR NOTE: The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The “correct combination” of codes may require the submission of multiple numerator codes.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Prescribed Inhaled Bronchodilator Therapy

(One CPT II code & one quality-data code [4025F & G8924] are required on the claim form to submit this numerator option)

Performance Met:

CPT II 4025F: Inhaled bronchodilator prescribed (NOTE: pending edited CPT II code)

AND

G8924: Spirometry test results demonstrate FEV1/FVC < 70%, FEV1 < 60% predicted and patient has COPD symptoms (eg, dyspnea, cough/sputum, wheezing) (NOTE: CMS approved edited G-code for 2017 PQRS year)

OR

Patient not Documented to have Inhaled Bronchodilator Prescribed for Medical, Patient, or System Reasons

(One CPT II code & one quality-data code [4025F-xP & G8924] are required on the claim form to submit this numerator option)

Append a modifier (1P, 2P or 3P) to CPT Category II code 4025F to report documented circumstances that appropriately exclude patients from the denominator.

Medical Performance Exclusion, Patient Performance Exclusion, or System Performance

Exclusion:

4025F with 1P: Documentation of medical reason(s) for not prescribing an inhaled bronchodilator (e.g., contraindication due to comorbidities)

4025F with 2P: Documentation of patient reason(s) for not prescribing an inhaled bronchodilator

4025F with 3P: Documentation of system reason(s) for not prescribing an inhaled bronchodilator (e.g., not covered by insurance)

AND

G8924: Spirometry test results demonstrate FEV1/FVC < 70%, FEV1 < 60% predicted and patient has COPD symptoms (eg, dyspnea, cough/sputum, wheezing)

OR

If patient is not eligible for this measure because spirometry results demonstrate FEV1/FVC ≥ 70% or FEV1 ≥ 60% predicted or patient does not have COPD symptoms, report:

Spirometry Results Demonstrate FEV1/FVC \geq 70% or FEV1 \geq 60% or Patient does not have COPD symptoms
(One quality-data code [G8925 or G8926] is required on the claim form to submit this numerator option)

Other Performance Exclusion: G8925: Spirometry test results demonstrate FEV1/FVC \geq 70% or FEV1 \geq 60% predicted or patient does not have COPD symptoms

OR

Spirometry Test not Performed or Documented

Other Performance Exclusion: G8926: Spirometry test not performed or documented, reason not given

OR

Patient not Documented to have Long-acting Inhaled Bronchodilator Prescribed, Reason not Otherwise Specified
(One CPT II code & one quality-data code [4025F-8P & G8924] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 4025F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

Performance Not Met:

4025F with 8P: Long-acting inhaled bronchodilator not prescribed, reason not otherwise specified

AND

G8924: Spirometry test results demonstrate FEV1/FVC $<$ 70%, FEV1 $<$ 60% predicted and patient has COPD symptoms (eg, dyspnea, cough/sputum, wheezing)

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

All patients aged 18 years and older with a diagnosis of COPD, who have FEV1/FVC $<$ 70%, FEV1 $<$ 60% predicted and have symptoms (eg, dyspnea, cough/sputum, wheezing)

S.7. Denominator Details (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 S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

All Patients aged \geq 18 years on date of encounter

AND

Diagnosis for COPD

ICD-9-CM [for use before 9/30/2014]:

491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 493.20, 493.21, 493.22, 496

ICD-10-CM [for use after 10/1/2014]:

J41.0, J41.1, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9

(Please see listing below for ICD-9/ICD-10 code definitions)

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

ICD-9/ICD-10 code definitions

ICD-9-CM [for use before 9/30/2014]:

491.0 – Simple chronic bronchitis
491.1 – Mucopurulent chronic bronchitis
491.20 – Obstructive chronic bronchitis without exacerbation
491.21 – Obstructive chronic bronchitis with (acute) exacerbation
491.22 – Obstructive chronic bronchitis with acute bronchitis
491.8 – Other chronic bronchitis
491.9 – Unspecified chronic bronchitis
492.0 – Emphysematous bleb
492.8 – Other emphysema
493.20 – Chronic obstructive asthma, unspecified
493.21 – Chronic obstructive asthma with status asthmaticus
493.22 – Chronic obstructive asthma with (acute) exacerbation
496 – Chronic airway obstruction, not elsewhere classified

ICD-10-CM [for use after 10/1/2014]:

J41.0 – Simple chronic bronchitis
J41.1 – Mucopurulent chronic bronchitis
J41.8 – Mixed simple and mucopurulent chronic bronchitis
J42 – Unspecified chronic bronchitis
J43.0 – Unilateral pulmonary emphysema [MacLeod's syndrome]
J43.1 – Panlobular emphysema
J43.2 – Centrilobular emphysema
J43.8 – Other emphysema
J43.9 – Emphysema, unspecified
J44.0 – Chronic obstructive pulmonary disease with acute lower respiratory infection
J44.1 – Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9 – Chronic obstructive pulmonary disease, unspecified

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

ATS continues to use the PCPI exception methodology that uses three categories of exception reasons for which a patient may be removed from the denominator of an individual measure: medical, patient and system reasons.

Exceptions are used to remove patients from the denominator of a performance measure when a patient does not receive a therapy or service AND that therapy or service would not be appropriate due to specific reasons; otherwise, the patient would meet the denominator criteria. Exceptions are not absolute, and the application of exceptions is based on clinical judgment, individual patient characteristics, or patient preferences. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions include medical reason(s), patient reason(s) or system reason(s) for not prescribing inhaled bronchodilators. Although this methodology does not require the external reporting of more detailed exception data, the ATS recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness.

S.9. Denominator Exclusion Details *(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 S.2b.)*

For Claims:

Patient not Documented to have Inhaled Bronchodilator Prescribed for Medical, Patient, or System Reasons
(One CPT II code & one quality-data code [4025F-xP & G8924] are required on the claim form to submit this numerator option)
Append a modifier (1P, 2P or 3P) to CPT Category II code 4025F to report documented circumstances that appropriately exclude

patients from the denominator.

Medical Performance Exclusion, Patient Performance Exclusion, or System Performance Exclusion:

4025F with 1P: Documentation of medical reason(s) for not prescribing a long-acting inhaled bronchodilator, e.g., contraindicated due to comorbidities

OR

4025F with 2P: Documentation of patient reason(s) for not prescribing inhaled bronchodilator

OR

4025F with 3P: Documentation of system reason(s) for not prescribing inhaled bronchodilator, e.g., not covered by insurance

AND

G8924: Spirometry test results demonstrate FEV1/FVC < 70%, FEV1 < 60% predicted and patient has COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)

NOTE: CMS approved edited G-code (correcting transcriptio error) for 2017 PQRS year and edited CPT II code is pending

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including 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 with at S.2b.)

We encourage the results of this measure to be stratified by race, ethnicity, primary language, and administrative sex.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. 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.14. Calculation Algorithm/Measure Logic (Diagram or 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; time period for data, aggregating data; risk adjustment; etc.)

NOTE: This sequence of steps has not been edited to reflect updated CPT II or G-codes. It will be edited once all updated CPT II or G-codes are finalized.

1. Start with Denominator
2. Check Patient Age:
 - a. If the Age is greater than or equal to 18 years of age on Date of Service and equals No during the measurement period, do not include in Eligible Patient Population. Stop Processing.
 - b. If the Age is greater than or equal to 18 years of age on Date of Service and equals Yes during the measurement period, proceed to check Patient Diagnosis.
3. Check Patient Diagnosis:
 - a. If Diagnosis of COPD as Listed in the Denominator equals No, do not include in Eligible Patient Population. Stop Processing.
 - b. If Diagnosis of COPD as Listed in the Denominator equals Yes, proceed to check Encounter Performed.
4. Check Encounter Performed:
 - a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Patient Population. Stop Processing.
 - b. If Encounter as Listed in the Denominator equals Yes, include in the Eligible population.

5. Denominator Population:
 - a. Denominator population is all Eligible Patients in the denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 8 patients in the sample calculation.
6. Start Numerator
7. Check Patient Prescribed Inhaled Bronchodilator Therapy AND Results of FEV1<60% Predicted and Patient has COPD Symptoms:
 - a. If Patient Prescribed Inhaled Bronchodilator Therapy AND Results of FEV1 <60% Predicted and Patient has COPD Symptoms equals Yes, include in Reporting Met and Performance Met.
 - b. Reporting Met and Performance Met letter is represented in the Reporting Rate and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 4 patients in Sample Calculation.
 - c. If Patient Prescribed Inhaled Bronchodilator Therapy AND Results of FEV1 <60% Predicted and Patient has COPD symptoms equals No, proceed to check Documentation of Medical Reason(s) for Not Prescribing Inhaled Bronchodilator Therapy AND Spirometry Results of FEV1 <60% Predicted and Patient has COPD Symptoms.
8. Check Documentation of Medical Reason(s) for Not Prescribing Inhaled Bronchodilator AND Spirometry Results of FEV1 <60% Predicted and Patient has COPD Symptoms:
 - a. If Documentation of Medical Reason(s) for Not Prescribing Inhaled Bronchodilator AND Spirometry Results of FEV1 <60% Predicted and Patient has COPD Symptoms equals Yes, include in Reporting Met and Performance Exclusion.
 - b. Reporting Met and Performance Exclusion letter is represented in the Reporting Rate and Performance Rate in the Sample Calculation listed at the end of this document. Letter b1 equals 1 patient in the Sample Calculation.
 - c. If Documentation of Medical Reason(s) for Not Prescribing Inhaled Bronchodilator AND Spirometry Results of FEV1 <60% Predicted and Patient has COPD Symptoms equals No, proceed to check Documentation of Patient Reason(s) for Not Prescribing Inhaled Bronchodilator AND Spirometry Results of FEV1 <60% Predicted and Patient has COPD Symptoms.
9. Check Documentation of Patient Reason(s) for Not Prescribing Inhaled Bronchodilator AND Spirometry Results of FEV1 <60% Predicted and Patient has COPD Symptoms:
 - a. If Documentation of Patient Reason(s) for Not Prescribing Inhaled Bronchodilator AND Spirometry Results of FEV1 <60% Predicted and Patient has COPD Symptoms equals Yes, include in Reporting Met and Performance Exclusion.
 - b. Reporting Met and Performance Exclusion letter is represented in the Reporting Rate and Performance Rate in the Sample Calculation listed at the end of this document. Letter b2 equals 0 patients in the Sample Calculation.
 - c. If Documentation of Patient Reason(s) for Not Prescribing Inhaled Bronchodilator AND Spirometry Results of FEV1 <60% Predicted and Patient has COPD Symptoms equals No, proceed to check Documentation of System Reason(s) for Not Prescribing Inhaled Bronchodilator AND Spirometry Results of FEV1 <60% Predicted and Patient has COPD Symptoms.
10. Check Documentation of System Reason(s) for Not Prescribing Inhaled Bronchodilator AND Spirometry Results of FEV1 <60% Predicted and Patient has COPD Symptoms:
 - a. If Documentation of System Reason(s) for Not Prescribing Inhaled Bronchodilator AND Spirometry Results of FEV1 <60% Predicted and Patient has COPD Symptoms equals Yes, include in Reporting Met and Performance Exclusion.
 - b. Reporting Met and Performance Exclusion letter is represented in the Reporting Rate and Performance Rate in the Sample Calculation listed at the end of this document. Letter b3 equals 0 patients in the Sample Calculation.
 - c. If Documentation of System Reason(s) for Not Prescribing Inhaled Bronchodilator AND Spirometry Results of FEV1 <60% Predicted and Patient has COPD Symptoms equals No, proceed to check Spirometry Results FEV1 = 60% Predicted OR Does not have COPD Symptoms.
11. Check Spirometry Results FEV1 = 60% Predicted OR does not have COPD Symptoms:
 - a. If Spirometry Results FEV1 = 60% Predicted OR Does not have COPD Symptoms equals Yes, include in Reporting Met and Performance Exclusion.
 - b. Reporting Met and Performance Exclusion letter is represented in the Reporting Rate and Performance Rate in the Sample Calculation listed at the end of this document. Letter b4 equals 0 patients in the Sample Calculation.
 - c. If Spirometry Results FEV1 = 60% Predicted OR Does not have COPD symptoms equals NO, proceed to check Spirometry Test Not Performed to Documented, Reason not Given.

12. Check Spirometry Test Not Performed to Documented, Reason Not Given:
 - a. If Spirometry Test Not Performed to Documented, Reason Not Given equals Yes, include in reporting met and performance exclusion.
 - b. Reporting Met and Performance Exclusion letter is represented in the Reporting Rate and Performance Rate in the Sample Calculation listed at the end of this document. Letter b5 equals 0 patients in the Sample Calculation.
 - c. If Spirometry Test Not Performed to Documented, Reason Not Given equals No, proceed to check Inhaled Bronchodilator not Prescribed, Reason Not Specified AND results of FEV1 = 60% Predicted and Patient has COPD Symptoms.
13. Check Inhaled Bronchodilator not Prescribed, Reason Not Specified AND Results of FEV1 = 60% Predicted and Patient has COPD Symptoms:
 - a. If Inhaled Bronchodilator not Prescribed, Reason not Otherwise Specified AND results of FEV1 = 60% Predicted and Patient has COPD Symptoms equals Yes, include in Reporting Met and Performance Not Met.
 - b. Reporting Met and Performance Not Met letter is represented in the Reporting Rate in the Sample Calculation listed at the end of this document. Letter c equals 2 patients in the Sample Calculation.
 - c. If Inhaled Bronchodilator not Prescribed, Reason not Otherwise Specified AND results of FEV1 = 60% Predicted and Patient has COPD Symptoms equals No, proceed to check Reporting Not Met.
14. Check Reporting Not Met
 - a. If Reporting Not Met equals No, Quality Data Code or equivalent not reported. 1 patient has been subtracted from reporting numerator in the sample calculation.

Please see Measure Flow in Appendix A.1 for 'Sample Calculation' referenced above.

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.
Not applicable. The measure does not require sampling or a survey.

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

N/A

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims, Registry Data

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

Not Applicable

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Outpatient Services

If other:

S.22. 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.)

This is not a composite measure

2. Validity – See attached Measure Testing Submission Form

0102_MeasureTesting_MSFS.0_Data-635313575706846894.doc,0102_testing_attachment_2015_amended_032516.docx

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

No

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

No

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition

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) Update this field for maintenance of endorsement.

ALL data elements are in defined fields in electronic claims

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

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. Please also complete and attach the NQF Feasibility Score Card.

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. Required for maintenance of endorsement. 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.

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

We have received comments that implementation of this measure remains complex. We agree the complexity of this measure, particularly from eligible professionals without programmable EHRs, could limit its use. Several documentation templates are available to facilitate data capture. ATS plans to assess ways to increase awareness of these templates to facilitate reporting.

Statement from 2012 comprehensive review submitted by PCPI to provide history.

The agreement rate and kappa statistic are not indications of a measure problem rather a measure implementation problem. During the first six months of the data collection period, the site did not collect the "documentation of presence of symptoms" in a discrete or searchable field. These findings were generally documented in the history and physical note. After an assessment of its collection methods, the site created a documentation template to capture the components of the numerator.

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).

N/A

RESPONSE TO ITEM 3b.2

ATS is considering eMeasures in the future. At this time we have not determined whether this measure will be converted.

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.

Specific Plan for Use	Current Use (for current use provide URL)
-----------------------	---

<p>Quality Improvement (Internal to the specific organization)</p>	<p>Public Reporting Physician Compare https://www.medicare.gov/physiciancompare/staticpages/data/aboutthedata.html</p> <p>Payment Program CMS PQRS https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html</p>
--	---

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

This measure is planned for integration into the CMS Physician Compare Program. Although Physician Compare has been launched, this measure is not yet included as of 12/14/15. The purpose of the Physician Compare Program is to help Medicare beneficiaries make informed choices about health care. The program is broadly available through the Physician Compare website noted above.

This measure has been in use for the CMS PQRI/S program since 2007. The PQRS is a quality reporting program to encourage individual eligible professionals and group practices to report quality information to Medicare. Effective in 2015, the PQRS will be used to apply a negative payment adjustment to individual eligible professionals and group practices who do not satisfactorily report data on quality measures for covered professional services provided to Medicare patients in 2013.

4a1.2. 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

4a1.3. 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

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.
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.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.
Describe how feedback was obtained.

4a2.2.2. Summarize the feedback obtained from those being measured.

4a2.2.3. Summarize the feedback obtained from other users

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

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.

4b1. Refer to data provided in 1b 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, 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.

This measure was initially developed for use in the PQRI/S program. Although not publically reported until the recent release of the new Physician Compare site, the performance trends indicate progress on increasing use of inhaled bronchodilators for the management of COPD from 2011-2014.

The ATS supports the goal of high-quality, efficient healthcare. Toward that goal, the ATS Quality Improvement Committee reviews performance annually as a component of measure maintenance and plans further analyses in the future. ATS participates in international COPD guideline development as well as conducts educational sessions and an annual meeting featuring use of guidelines, including appropriate bronchodilator use.

4b2. 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).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

We are not aware of any unintended consequences related to this measurement.

4b2.2. Please explain any unexpected benefits from implementation of this 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.
No

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

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

5a. Harmonization of Related Measures

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 harmonized to the extent possible?

Yes

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

5b. Competing Measures

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

OR

Multiple measures are justified.

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

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

N/A

COMMENT ON 5a.1 - N/A is not a selection. For this reason, we select yes. There are no competing measures to harmonize.

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: 0102_measure_flow_2015_form_no_s.19_.doc

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): American Thoracic Society

Co.2 Point of Contact: Gary, Ewart, gewart@thoracic.org, 202-296-9770-

Co.3 Measure Developer if different from Measure Steward: American thoracic Society

Co.4 Point of Contact: Joseph, Ruminjo, jruminjo@thoracic.org, 646-591-3747-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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

This measure was initially developed in 2007 by the AMA-PCPI, working with the ATS.

PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study are invited to participate as equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

The initial Work Group Panel consisted of:

William E. Golden, MD, FACP, co-chair

Linus Santo Tomas, MD, MS, co-chair
Bruce Bagley, MD (AAFP)
Troy T. Fiesinger, MD (AAFP)
David G. Jaimovich, MD (SCCM)
Bruce Krieger, MD (ATS)
Thomas W. Lukens, MD, PhD, FACEP (ACEP)
Susan Nedza, MD, MBA, FACEP (CMS)
Deborah Patterson, MS, RN (BCBSA)
Sam J. W. Romeo, MD, MBA
Ralph M Schapira, MD (VA)
Sean D. Sullivan, RPh, PhD
Dennis E. Richling, MD
Nancy Lawler, RN (Joint Commission)

Stewardship of this measure was transferred to the ATS in November 2014.

To prepare for the 2015 NQF comprehensive review, ATS formed the Quality Improvement Committee Sub-committee on COPD Measures to review and update this measure. The Sub-committee members include:

Laura Feemster, MD, MS, VA Puget Sound Health Care System, University of Washington Medical Center, Chair
Bela Patel, MD, The University of Texas Health Science Center at Houston
Carolyn Fruci, MD, Prima-CARE, PC
David Au, MD, MS, VA Puget Sound Health Care System, University of Washington Medical Center
Jerry A. Krishnan, MD, PhD, University of Illinois at Chicago
Gary Ewart, Chief, Advocacy & Government Relations, ATS
Sue Frechette, RN, MBA, Consultant, Northfield Associates LLC

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2007

Ad.3 Month and Year of most recent revision: 12, 2011

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

Ad.5 When is the next scheduled review/update for this measure? 12, 2020

Ad.6 Copyright statement: The Measures are not clinical guidelines, do not establish a standard of medical care, and have not been tested for all potential applications.

The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain.

Commercial uses of the Measures require a license agreement between the user and the PCPI® Foundation (PCPI®) or the American Thoracic Society (ATS). Neither ATS, nor the American Medical Association (AMA), nor the AMA-convened Physician Consortium for Performance Improvement® (AMA-PCPI), now known as PCPI, nor their members shall be responsible for any use of the Measures.

The AMA's and AMA-PCPI's significant past efforts and contributions to the development and updating of the Measures is acknowledged. ATS is solely responsible for the review and enhancement ("Maintenance") of the Measures as of September 8, 2014.

ATS encourages use of the Measures by other health care professionals, where appropriate.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

© 2015 PCPI® Foundation and American Thoracic Society. All Rights Reserved.

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. ATS, the AMA, the PCPI and its members and former members of

the AMA-PCPI disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

CPT® contained in the Measures specifications is copyright 2004-2015 American Medical Association. LOINC® copyright 2004-2015 Regenstrief Institute, Inc. SNOMED CLINICAL TERMS (SNOMED CT®) copyright 2004-2015 The International Health Terminology Standards Development Organisation (IHTSDO). ICD-10 is copyright 2015 World Health Organization. All Rights Reserved.

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: Coding/Specifications updates occur annually. ATS plans to continue measurement review process that stipulates regular (usually on a three-year cycle, when feasible) review of the measures. ATS will also review the measures if there is a major change in scientific evidence, results from testing or other issues are noted that materially affect the integrity of the measure.