



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 #: 2020

Corresponding Measures:

De.2. Measure Title: Adult Current Smoking Prevalence

Co.1.1. Measure Steward: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion

De.3. Brief Description of Measure: Percentage of adult (age 18 and older) U.S. population that currently smoke.

1b.1. Developer Rationale: Measuring smoking status has many benefits. It is also essential for developing effective cessation and prevention campaigns, since smoking prevalence data shows where the greatest need is for interventions and allows for the evaluation of the impact of present campaigns and shows important areas for improvement. It is also important for informing tobacco-control policies that have a positive impact on reducing smoking rates. Data on smoking prevalence is also crucial in identifying inequalities between groups and addressing health disparities.

A specific example of the importance of tracking smoking status can be found in Legacy's report, "Saving Lives, Saving Money," which addresses the financial impact of smoking. In the report, researchers estimated the reduction in state Medicaid expenditures that would result from reducing or eliminating smoking through effective cessation and prevention programs. In order to calculate the lifetime costs of a smoker to a state Medicaid program, data on smoking status was essential.

Information from the Legacy report, "Saving Lives, Saving Money":
<https://www.tobaccofreekids.org/assets/content/pressoffice/278055.PN.pdf>

S.4. Numerator Statement: The numerator is current adult smokers (age 18 and older) in the U.S. who live in households.

S.6. Denominator Statement: The adult (age 18 and older) population of the U.S. who live in households. One adult per household is interviewed.

S.8. Denominator Exclusions: Adults 18 years or older are asked to take part in the survey and only one adult is interviewed per household. Adults living in vacation homes not occupied by household members for more than 30 days per year, group homes, institutions, prisons, hospitals and college dorms are excluded. Military services members and adults who speak a language other than English and Spanish are also excluded.

De.1. Measure Type: Outcome

S.17. Data Source: Other

S.20. Level of Analysis: Other, Population : Regional and State

IF Endorsement Maintenance – Original Endorsement Date: Oct 19, 2012 **Most Recent Endorsement Date:** Oct 19, 2012

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. **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

[NQF_evidence_attachment_Sep2017.docx](#)

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.

Measuring smoking status has many benefits. It is also essential for developing effective cessation and prevention campaigns, since smoking prevalence data shows where the greatest need is for interventions and allows for the evaluation of the impact of present campaigns and shows important areas for improvement. It is also important for informing tobacco-control policies that have a positive impact on reducing smoking rates. Data on smoking prevalence is also crucial in identifying inequalities between groups and addressing health disparities.

A specific example of the importance of tracking smoking status can be found in Legacy's report, "Saving Lives, Saving Money," which addresses the financial impact of smoking. In the report, researchers estimated the reduction in state Medicaid expenditures that would result from reducing or eliminating smoking through effective cessation and prevention programs. In order to calculate the lifetime costs of a smoker to a state Medicaid program, data on smoking status was essential.

Information from the Legacy report, "Saving Lives, Saving Money":

<https://www.tobaccofreekids.org/assets/content/pressoffice/278055.PN.pdf>

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.

Challenges to Developing a Body of Knowledge about the Effects of Mass Media Campaigns by SES or Race/ethnicity

The lack of evidence related to the effects of public health interventions to reduce tobacco use with respect to SES or race/ethnicity is often due to funding constraints, making it difficult to conduct appropriate formative research and which often results in insufficient sample sizes for racial/ethnic subgroups. This issue is compounded by inconsistent evaluation measures and analytic approaches, which also hinders comparison across those few studies that are conducted. Each of these issues is discussed in greater detail below.

Costs Associated with Conducting Formative Research

Developing and implementing a campaign requires extensive planning, dedicated staff time, and establishment of relationships with vendors, contractors, media and creative agencies, all of which can be costly. Consider the case of an agency that has obtained funding to air a local or state-wide mass media campaign at a fairly low level of GRPs and for an undetermined length of time. Such an agency may not feel they have the resources—financial or otherwise—to conduct formative research with several segments of the target audience. Formative research would entail, at the very least, conducting focus groups of individuals recruited from these populations to generate concepts for the campaign, the brand and the messaging. After a subsequent period of creative development, the campaign concept and messages should be pre-tested with the audience. A third round of testing would ideally

be conducted to assess the advertising executions prior to their airing publicly.

Organizations that feel they don't have the resources to conduct formative research will often make decisions about the messaging based on existing research or on their own intuition. Unfortunately, what has worked well in one set of circumstances may not necessarily translate to another setting, and messages that are developed without input from the target audience may not be well-received, or may have unintended effects. The best advertising campaigns are designed and executed with substantive input from the specific target audience.

Costs Associated with Evaluation

In order to determine whether a campaign has impacted the awareness, cognitions or behavior of a group of individuals, one must have a sufficient sample size with which to conduct the analysis. This is referred to as "power." Since the expected overall effects of mass media campaigns are relatively small, larger sample sizes are generally needed in order to have an adequately powered sample. If a sample is 'underpowered,' it is possible to statistically calculate a null effect even if the campaign is producing 'true' effects in a population (the problem of a false negative). Unfortunately, because many evaluation initiatives are limited by funding constraints, they often do not achieve an adequate sample size to determine whether there was a campaign effect within racial/ethnic or other subgroups.

n/a

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.

One challenge or limitation with this measure is that studies of various smoking measures have found that prevalence rates differ based on different measures/definitions and that these differences vary by sub-population.

Ryan H, Trosclair A, Gfroerer J. Adult current smoking: differences in definitions and prevalence estimates—NHIS and NSDUH, 2008. J Environ Public Health. 2012;2012.

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.

In 1964, the release of the Surgeons General's Report marked the commencement of efforts to inform the American public of the serious health consequences of tobacco use. This landmark event occurred when 43% of Americans over age 18 smoked cigarettes, including about half of all men and one third of all women (NHIS 1965 data) (USDHHS, 1989). Over four decades later, the US adult smoking rate has declined to 20% (NHIS 2007 data) (Schiller, Heyman and Barnes, 2008). Today, as in the mid-1960s, smoking and smoking-attributable disease reflect a socioeconomic position (SEP) gradient such that those with greater resources smoke at lower rates, quit at higher rates, and experience lower rates of morbidity and mortality from tobacco use (USPHS, 1964; USDHHS, 1989; Giovino, 2002; Fagan, Shavers, Lawrence, et al., 2007; Albano, Ward, Jemal et al., 2007). Since 1964, however, smoking and smoking-attributable disease have become increasingly concentrated among the most poor and least educated segments of U.S. society. From 1966 to 2006, current smoking declined by 76% among college graduates, 48% among those with some college, 36% among those with a high school degree/GED and 21% among those who did not finish high school (USDHHS, 1989; Pleis and Lethbridge-Cejku, 2007). Today, only 8% of college graduates smoke, compared with 26% of those with a high school degree/GED (NHIS 2006) (Pleis and Lethbridge-Cejku, 2007).

Numerous studies demonstrate an association between socioeconomic position and adverse health outcomes related to tobacco use (USPHS, 1964; Marmot and McDowall, 1987; Devesa, Diamond, 1983; Wong, Shapiro, Boscardin et al., 2002; Lawlor, Sterne, Tynelius, et al., 2006; Albano, Ward, Jemal et al., 2007).

Individuals with lower levels of education and income are more likely than others to experience a period without health insurance, most often as a result of cost or a lapse in Medicaid coverage (Adams, Lucas, Barnes, 2008). Not surprisingly, these individuals are also more likely to report delaying or not receiving medical care due to cost (Adams, Lucas, Barnes, 2008). A recent study shows that education and income are negatively associated with successful quitting, particularly in the long term (Fagan, Shavers, Lawrence, et al., 2007). Race and ethnicity play a role. Several studies show that African American and Hispanic smokers are less likely than white

smokers to be advised by a physician to quit; an intervention associated with a 30% greater likelihood of quitting (Hymowitz N, Jackson J, Carter, et al., 1996; Levinson, Pérez-Stable, Espinoza et al., 2004; Cokkinides, Halpern, Barbeau, 2008; Fiore, Bailey, Cohen, et al., 2000). African American and Hispanic smokers are also less likely than white smokers to report use of cessation aids, perhaps for cultural reasons (Hymowitz N, Jackson J, Carter, et al., 1996; Levinson, Pérez-Stable, Espinoza et al., 2004; Cokkinides, Halpern, Barbeau, 2008; Yeger, Wertz, McGruder, et al., 2008).

A recent report from the National Cancer Institute highlights tobacco-related disparities across many populations.

<https://cancercontrol.cancer.gov/brp/tcrb/monographs/22/index.html>

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

n/a

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the 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):

Behavioral Health, Behavioral Health : Alcohol, Substance Use/Abuse, Cancer, Cancer : Lung, Esophageal, Cardiovascular, Cardiovascular : Congestive Heart Failure, Cardiovascular : Coronary Artery Disease (AMI), Cardiovascular : Hypertension, Perinatal Health, Perinatal Health : Newborn Care, Respiratory : Asthma

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

Primary Prevention

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.)

<http://www.cdc.gov/brfss/>

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.

Attachment Attachment: 2017_BRFSS_Survey.pdf

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.

Patient

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.

I changed this measure from a structural measure to an outcome measure. Based on the definitions of these measure types, this seemed to fit better.

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).

The numerator is current adult smokers (age 18 and older) in the U.S. who live in households.

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).

The numerator, Adult Current Smoking, is a measure collected by means of the Behavioral Risk Factor Surveillance System (BRFSS), a state-based system of health surveys that generate information about health risk behaviors, clinical preventive practices, and health care access and use primarily related to chronic diseases and injury. The BRFSS is conducted by the Centers for Disease Control and Prevention (CDC). The BRFSS has been conducted since its beginning in 1984 with the goal of collecting state-specific estimates of health risk behavior data. By 1994, all states, the District of Columbia, and three territories were participating in the BRFSS.

Adults 18 years or older are asked to take part in the survey and only one adult is interviewed per household. Adults living in vacation homes not occupied by household members for more than 30 days per year, group homes, institutions, prisons, hospitals and college dorms are excluded. Military service members and adults who speak languages other than English and Spanish are also excluded.

Information obtained from:

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6122a3.htm?s_cid=mm6122a3_w

<ftp://ftp.cdc.gov/pub/Data/Brfss/userguide.pdf>

<http://dhds.cdc.gov/methods>

The measure is composed of two survey items, both of which respondents must endorse in order to be considered current smokers (below). See this BRFSS document for details:

http://www.cdc.gov/brfss/technical_infodata/surveydata/2010.htm

Section 7: Tobacco Use

7.1 Question Text: Have you smoked at least 100 cigarettes in your entire life? NOTE: 5 packs = 100 cigarettes

1 Yes

2 No

7 Don't know / Not sure

9 Refused

Question Text:

Do you now smoke every day, some days, or not at all (asked of those who smoked 100 cigarettes in the above question)?

1 Every day

2 Some days

3 Not at all
7 Don't know / Not sure
9 Refused

BRFSS is a cross-sectional telephone survey conducted by state health departments with technical and methodological assistance provided by the CDC. The data is collected monthly via telephone and all data is then forwarded to the CDC, where it is aggregated for each state. The data is then returned to the states and then published on the BRFSS website.

Information from: <http://www.cdc.gov/brfss/faqs.htm>

Citation for survey questions:

Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Questionnaire. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2010.

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

The adult (age 18 and older) population of the U.S. who live in households. One adult per household is interviewed.

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).

The denominator, the adult population of the U.S., is a measure collected by means of the Behavioral Risk Factor Surveillance System (BRFSS), a state-based system of health surveys that generate information about health risk behaviors, clinical preventive practices, and health care access and use primarily related to chronic diseases and injury. The BRFSS is conducted by the Centers for Disease Control and Prevention (CDC). The BRFSS has been conducted since its beginning in 1984 with the goal of collecting state-specific estimates of health risk behavior data. By 1994, all states, the District of Columbia, and three territories were participating in the BRFSS.

Information from:

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6122a3.htm?s_cid=mm6122a3_w

<ftp://ftp.cdc.gov/pub/Data/Brfss/userguide.pdf>

<http://dhds.cdc.gov/methods>

The survey is conducted among the adult (age 18 and older) U.S. civilian, noninstitutionalized population, and is weighted to U.S. census data so that it is nationally representative.

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

Adults 18 years or older are asked to take part in the survey and only one adult is interviewed per household. Adults living in vacation homes not occupied by household members for more than 30 days per year, group homes, institutions, prisons, hospitals and college dorms are excluded. Military services members and adults who speak a language other than English and Spanish are also excluded.

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.)*

Adults living in vacation homes not occupied by household members for more than 30 days per year, group homes, institutions, prisons, hospitals and college dorms are excluded. Military services members and adults who speak a language other than English and Spanish are also excluded.

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.)*

The BRFSS questionnaire is made up of three parts. The core component is the standard set of questions asked by all of the states. This component includes questions about current health-related perceptions, conditions, and behaviors (such as tobacco use and HIV/AIDS risks) and demographic questions. The second part of the BRFSS is the optional CDC modules, which are sets of questions about specific topics, such as women's health, that states can choose to use on their questionnaires. These sections are agreed upon each year by the states and CDC. Many questions are taken from established national surveys in order to ensure that questions have been tested and also to allow BRFSS data to be compared to results from other national surveys. Any new questions are subjected to cognitive testing and field testing before being added to the survey.

The third part of the BRFSS is state-added questions, which are questions that are developed and obtained by participating states and added to their questionnaires. This section of the BRFSS is the only part that is not edited or evaluated by CDC. States are selective about which optional modules and state-specific questions they include in their survey.

In the past, post-stratification weights are used, which may partially correct for any bias caused by non-telephone coverage. These weights adjusted for differences in probability of selection and nonresponse, as well as noncoverage, and must be used for getting representative population-based estimated of risk behavior prevalence. As of 2011, the BRFSS has adopted an advanced weighting method called iterative proportional fitting, also known by its nickname, "raking." "Raking is different from post-stratification because" it incorporates adjustor variables one at a time in an iterative process, rather than imposing weights for demographic subgroups in a single process" (BRFSS FAQs). An advantage of this is that many more variables are used than post stratification.

Information from:

http://www.cdc.gov/surveillancepractice/reports/brfss/brfss_faqs.html

http://www.cdc.gov/brfss/technical_infodata/surveydata/2011.htm

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 = Lower 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.)

NA

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.

Please see documentation for the BRFSS: <ftp://ftp.cdc.gov/pub/Data/Brfss/userguide.pdf>

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.

Other

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.

BRFSS. Please see: http://www.cdc.gov/brfss/technical_infodata/surveydata/2011.htm

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)

Available at measure-specific web page URL identified in S.1

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

Other, Population : Regional and State

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

Other

If other: Specified for general population, including adults/elderly, young adults and populations at risk.

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.)

2. Validity – See attached Measure Testing Submission Form

[Brfss_reliability.pdf](#), [Smoking_BRFSS.pdf](#)

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.

Other

If other: BRFSS data is collected by each state health department monthly and sent to CDC, which compiles the data yearly.

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 a combination of 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. 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.

Although there are some threats to the validity of BRFSS data, such as the exclusion of individuals without landlines, BRFSS data has been found to be both valid and reliable compared to other national surveys (CDC, 2003). Since the BRFSS is the largest telephone survey in the world, its ongoing data collection and substantial sample size “allows for stratification to further examine the risk by selected variables of interest”(CDC, 2003).

Centers for Disease Control and Prevention. Public health surveillance for behavioral risk factors in a changing environment: recommendations from the Behavioral Risk Factor Surveillance Team. MMWR 2003;52 (No. RR-9): 1-12. MMWR. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/12817947>.

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*).

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)
Public Reporting	Public Health/Disease Surveillance BRFSS https://www.cdc.gov/BRfSS/

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

Centers for Disease Control and Prevention

Purpose is to "collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services."

National survey of US adults; "BRFSS completes more than 400,000 adult interviews each year"

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?)

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.)

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.

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.

Interview procedures are designed to minimize errors in data collection. However, there are still opportunities for error. One type of error is noncoverage error, which occurs when not all members of the general population are included in the sample. For example, those purposely excluded from the survey, such as those living in institutions, as well as those without telephones, may result in noncoverage errors. To minimize the effects of noncoverage errors, data is often weighted to account for adults without telephones, for example. However, starting in 2011, the BRFSS has begun making interview calls to people with cellular phones.

Another potential error is a sampling error, which occurs because estimates are based on a sample of a population rather than the entire population.

Nonresponse error also occurs. This can occur when respondents are not available or refuse to participate in the survey or when respondents refuse to answer specific survey questions or answer them untruthfully.

Measurement error refers to the validity of a variable. Factors that may bias responses and thus lead to measurement errors are: wording, format and order of questions, interviewer's adherence to wording, and mistakes made in the editing and coding of data. Measurement errors can be decreased if the questions are phrased properly on the questionnaire, read properly by the interviewer, understood and answered truthfully by the respondent, and checked for errors.

Information found here:

<ftp://ftp.cdc.gov/pub/Data/Brfss/userguide.pdf>

http://www.cdc.gov/surveillancepractice/reports/brfss/brfss_faqs.html

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.

Yes

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

0028 : Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

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.)

The only other tobacco and smoking related measures are those that involve clinicians screening for individual-level tobacco use. This measure provides estimates of population-level smoking, which is a public health measure.

Appendix

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

No appendix Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion

Co.2 Point of Contact: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, cdcinfo@cdc.gov, 888-232-6348-

Co.3 Measure Developer if different from Measure Steward: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion

Co.4 Point of Contact: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, cdcinfo@cdc.gov, 888-232-6348-

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. NA
Measure Developer/Steward Updates and Ongoing Maintenance Ad.2 Year the measure was first released: Ad.3 Month and Year of most recent revision: 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?
Ad.6 Copyright statement: NA Ad.7 Disclaimers: NA
Ad.8 Additional Information/Comments: To clarify the final section on contact information, CDC is the developer and intellectual property owner of the measure. This form, however, was filled out by Truth Initiative.