



December 5, 2008

Ms. Katie Burns  
Health Economics Program  
Minnesota Department of Health  
Golden Rule Building  
85 East 7<sup>th</sup> Place, Suite 220  
St. Paul, MN 55101

Dear Ms. Burns:

MN Community Measurement is pleased to submit the attached inventory of Quality Measures, produced by the University of Minnesota with assistance from Stratis Health, the Minnesota Medical Association and the Minnesota Hospital Association. As you know, the inventory is the first step in the effort this group will be undertaking with the Minnesota Department of Health to build upon and enhance the significant quality measurement strides that have already been made in Minnesota. We look forward to continuing to work with you.

Sincerely,

Jim Chase, President  
MN Community Measurement

**Quality Measures Inventory**  
**Report to Minnesota Community Measurement**

Submitted by the

**University of Minnesota**

In collaboration with

**Stratis Health**

**Minnesota Medical Association**

**Minnesota Hospital Association**

**December 5, 2008**

## Table of Contents

Section I – Introduction.....	2
Section II – Background .....	4
Section III – Using the National Quality Measurement Clearinghouse (NQMC) Data Base.....	8
Section IV – Measures of Interest Not Found in the NQMC .....	30
Section V – Measures in Use in Minnesota.....	34
Section VI – Prioritizing Measures for Minnesota – Overview .....	44
Appendices:	
Appendix A – Example measure searches and comparison using the NQMC.....	45
Appendix B – Example measures from the MMIC.....	61
Attachment I – List of measures included in the NQMC .....	

## **Section I – Introduction**

The purpose of this report is to provide a comprehensive inventory of quality measures being developed and used in the U.S. for hospitals and clinics. The inventory will be a resource to support a prioritization process and decision making to determine new measures for hospitals and clinics that will be implemented by the State. The inventory is the result of combining and building on the previous related work of the following organizations:

- Agency for Health Care Quality and Research (AHRQ) National Quality Measures Clearinghouse (NQMC)
- Minnesota Community Measurement
- Stratis Health
- Minnesota Medical Association
- Minnesota Hospital Association

The University of Minnesota served to coordinate input from the sources above and compile the inventory. After we began to explore alternative approaches to developing the inventory, we determined that the AHRQ National Quality Measures Clearinghouse (NQMC) was a single resource that with its comprehensiveness, depth of information on specific measures, and ease of conducting searches for focused comparison of measures, had achieved most of the objectives of the State regarding an inventory, with the exception of a relatively small number of measures identified that were not included in the AHRQ data base and also information about measures in current use in Minnesota.

The NQMC includes over 1,400 developed measures and tracks over 500 measures under development. Each measure has been given a unique name and numerical ID. The information on the measures is extensive and addresses virtually all of the information requested by the State. NQMC even met our objective for an easily searchable data base for selecting measures by applying a large number of attributes of the measures. It includes measures in use by a number of entities such as the Institute for Clinical Improvement. NQMC includes an extensive collection of specialist quality measures that have been developed by professional societies and vetted through the AMA collaborative process. It includes measures on hospitals, nursing homes, and home health. It identifies the IOM aim addressed by each measure.

Extensive and detailed information that is provided for each measure captured all of the following attributes that was requested in the RFP, except for Minnesota use information.

Examples of attributes included in the RFP and addressed in the NQMC:

- Unique measure ID and name
- Institute of Medicine aim being addressed
- Name of measure in other measure sets

- Source /Initiative (e.g. NCQA)
- Clinical condition
- Population (age/gender/program/etc.)
- Part of delivery system being measured
- Description of the measure / Relationship to desired health outcome/  
Evidence-base
- Domain: (Structure / Process / Outcome / Patient experience/ etc.)
- Data source(s)
- Current use status in US (examples of users and uses / Under development)
- Method for calculating the measure / inclusion and exclusion criteria
- Availability of state or national data that can be used to benchmark

Our conclusion is that since the inventory objectives are largely and competently addressed by NQMC, our tasks for the inventory should be to:

- 1) Present the measures and functionality of the NQMC and become skilled in using the NQMC data base to support the process of measure evaluation and prioritization
- 2) Identify measures that may be of interest, but are not in the NQMC
- 3) Identify measures in use in Minnesota
- 4) Build upon the NQMC by reviewing the feasibility and relevance of the measures

To support the entire University of Minnesota activity related to the MNCM project, we have retained a research assistant who is a master level student in health care administration with health care work experience. He has studied the extensive capabilities of the NQMC data base and will become fully trained in its use. We propose that this RA will be able to 1) train others in the use of NQMC and 2) conduct customized and timely searches of the NQMC to support the continuing work of the State through spring of 2009. The RA will be available to MNCM.

### *Inventory Report Organization*

The inventory is organized as follows:

Section I – Introduction

Section II – Provides a brief introduction to quality measurement organizations nationally

Section III – Describes the National Quality Measures Clearinghouse (NQMC)

Section IV – Identifies measures not found in the NQMC

Section V – Identifies measures being used in Minnesota

Section VI – Presents high level issues to consider in evaluating measures for Minnesota

Appendix A – Provides examples of searches and measures comparisons using the National quality Measures Clearinghouse

Appendix B – Provides sample measures from the MMIC

Attachment I – Provides a lengthy, but the most abbreviated list available of the NMQM measures

## **Section II – Background**

Quality performance measurement has been an organized effort of a number of national and regional organizations representing health care purchasers, consumers, policy decision makers, and providers. In recent years, the activities of these numerous entities have become more collaborative and coordinated. Now quality performance measures are generally reviewed by high level collaboratives of these organizations, regardless of where the measure originated historically. The desire to standardize measures crosses stakeholders. Providers need to have more coherence of measures. They need the measures that have passed thorough scrutiny. Purchasers and policymakers in our pluralistic health care purchasing system need to increase penetration within a provider's patient population in order to reach "critical mass" for change and to produce value-based incentive systems.

The following briefly describes selected key national organizations involved with health care quality measure development and evaluation:

1. *National Committee for Quality Assurance (NCQA)* – The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to improving health care quality. NCQA has helped to build consensus around important health care quality issues by working with large employers, policymakers, doctors, patients and health plans to decide what's important, how to measure it, and how to promote improvement. NCQA develops quality standards and performance measures for a broad range of health care entities. It is with these measures and standards that organizations and individuals can identify opportunities for improvement.

Source: <http://www.ncqa.org/tabid/675/Default.aspx>

2. *National Quality Forum (NQF)* – The National Quality Forum (NQF) is a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting. Leaders in the public and private sector were prompted to create NQF as a mechanism to bring about national change in health care quality on patient outcomes, workforce productivity, and health care costs. The organizational members of the NQF

work together to promote a common approach to measuring health care quality and fostering system-wide capacity for quality improvement.

Source: <http://www.qualityforum.org/about/>

3. *Agency for Healthcare Research and Quality (AHRQ)* – As a health services research arm of the U.S. Department of Health and Human Resources, the Agency for Healthcare Research and Quality (AHRQ) works with public and private sectors to build a knowledge base for what works, and for what does not work, in health and health care and to translate this knowledge into everyday practice and policymaking. AHRQ’s main goals are to support improvements in health outcomes, develop strategies to strengthen quality measurement and improvement, and to identify healthcare strategies to improve health cost access, foster appropriate use, and reduce unnecessary expenditures in healthcare.  
Source: <http://www.ahrq.gov/about/whatis.htm>
4. *Hospital Quality Alliance (HQA)* – In December 2002, the organizations representing America's hospitals joined with consumer representatives, physician and nursing organizations, employers and payers, oversight organizations and government agencies to launch the Hospital Quality Alliance (HQA). The HQA is a national public-private collaboration that is committed to making meaningful, relevant, and easily understood information about hospital performance accessible to the public. It also informs and encourages efforts to improve quality by using clinical quality, patient experience, equity, efficiency, and pricing information to spur positive changes in health care delivery.  
Source: <http://www.hospitalqualityalliance.org>
5. *Ambulatory Quality Alliance (AQA)* – In 2004, the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), America’s Health Insurance Plans (AHIP), and the Agency for Healthcare Research and Quality (AHRQ), joined together to determine how to most effectively and efficiently improve performance measurement, data aggregation, and reporting in the ambulatory care setting. Originally known as the Ambulatory Care Quality Alliance, the coalition is now known as the AQA alliance, because its mission has broadened to incorporate all areas of physician practice. AQA’s mission and goals focus on areas that can help identify quality gaps, control skyrocketing cost trends, reduce confusion over redundant measures and alleviate administrative burdens in the marketplace.  
Source: <http://www.aqaalliance.org/default.htm>
6. *The Joint Commission* is an independent, not-for-profit organization that accredits and certifies more than 15,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards. The Joint Commission’s mission is to continuously improve the safety and quality of care provided to the

public through the provision of health care accreditation and related services that support performance improvement in health care organizations.

Source: <http://www.jointcommission.org/AboutUs/>

7. *American Medical Association (AMA)* – As the nation’s largest association of physicians and medical students in the United States, the American Medical Association (AMA) advocates on the issues vital to the nation’s health. AMA’s mission is to promote the art and science of medicine and the betterment of public health. Their goal is to unite physicians nationwide to work on the most important professional and public health issues. By 2010, the AMA’s goal will be to combine national Medicare and private health plan claims data and then use the data for public reporting of physician performance on quality and cost measures.

Source: <http://www.ama-assn.org/ama/pub/category/1815.html>

The national structure for quality measurement development, testing, and approval is centered on the National Quality Forum (NQF). NQF is a collaborative with support across the spectrum of stakeholders. Minnesota will need to consider the national priority agenda as it selects measures for the State. (Note: The measures being addressed by this collaborative are all included in the AHRQ NQMC data base.)

Included in the “National Priorities Partners” agenda setting process are the following organizations:

- National Partnership for Women and Families
- Consumers Union
- AARP
- AFL-CIO
- National Business Group on Health
- The Leapfrog Group
- Pacific Business Group on Health
- Chamber of Commerce
- Ambulatory Quality Alliance (AQA)
- Hospital Quality Alliance (HQA)
- Quality Alliance Steering Committee
- Alliance for Pediatric Quality
- AMA’s Physician Consortium for Performance Improvement (PCPI)
- American Nurses Association
- American Board of Medical Specialties
- National Association of Community Health Centers
- Joint Commission
- National Committee for Quality Assurance
- Certification Commission for Healthcare Information Technology
- Centers for Disease Control and Prevention
- Centers for Medicare and Medicaid Services (CMS)



- Agency for Healthcare Research and Quality (AHRQ)
- National Institutes of Health
- National Governors Association
- America's Health Insurance Plans
- Institute for Healthcare Improvement
- Institute of Medicine (IOM)

The NQF national priority objectives are to: 1) center on high-leverage areas to achieve high return on investment, 2) harmonize efforts of “multiple groups” around common goals for improvement, and 3) emphasize the urgent need to drive fundamental change in delivery system.

NQF has recently determined the national priority areas for quality measurement for improvement:

- 1) *Patient and family engagement* – Engage patients and their families in managing health and making decisions about care  
 Areas of focus:
  - Patient experience of care
  - Patient self-management
  - Informed decision making
- 2) *Population health* – Improve the health of the population  
 Areas of focus:
  - Healthy lifestyle behaviors
  - Preventive care
  - Community index to assess health status
- 3) *Safety* – Improve the safety and reliability of America's health care system  
 Areas of focus:
  - Healthcare-associated infections
  - Serious adverse events
  - Mortality
- 4) *Care coordination* – Ensure patients receive well-coordinated care across all providers, settings, and levels of care  
 Areas of focus:
  - Medication reconciliation
  - Preventable hospital readmissions
  - Preventable emergency department visits
- 5) *Palliative care* – Ensure patients receive well-coordinated care across all providers, settings, and levels of care  
 Areas of focus:
  - Medication reconciliation
  - Preventable hospital readmissions

- Preventable emergency department visits
- 6) *Overuse* – Eliminate overuse while ensuring the delivery of appropriate care  
 Areas of focus:
- Inappropriate medication use
  - Unnecessary lab tests
  - Unwarranted maternity care interventions
  - Unwarranted diagnostic procedures
  - Unwarranted procedures
  - Unnecessary consultations
  - Preventable emergency department visits and hospitalizations
  - Inappropriate non-palliative services at end of life
  - Potentially harmful preventive services with no benefit

(Source: NQF)

Distinct differences exist between hospital measures and reporting, and outpatient/clinic measures and reporting. The measurement of hospital quality performance has been largely driven by national requirements, especially by CMS and the Joint Commission, and a national system of data collection. To be as cost-effective as possible, work on hospital measures will be built upon the national efforts. The measurement of clinic quality and performance has developed primarily from the local or state-based realm, and has only more recently had national efforts, such as CMS' PQRI program (Physician Quality Reporting Initiative). We will draw upon expertise and experience specific to Minnesota to bridge these two very different measurements and reporting realms.

### **Section III – Using the National Quality Measurement Clearinghouse Data Base**

The AHRQ National Quality Measures clearinghouse is a remarkable resource for planners wishing to implement quality measures. The website describes the NQMC as follows:

“The National Quality Measures Clearinghouse™ (NQMC), sponsored by the Agency for Healthcare Research and Quality (AHRQ) U.S. Department of Health and Human Services, is a database and Website for information on specific evidence-based health care quality measures and measure sets. NQMC is sponsored by AHRQ to promote widespread access to quality measures by the health care community and other interested individuals.

The NQMC mission is to provide practitioners, health care providers, health plans, integrated delivery systems, purchasers and others an accessible mechanism for obtaining detailed information on quality measures, and to further their dissemination, implementation, and use in order to inform health care decisions. NQMC builds on AHRQ's previous

initiatives in quality measurement, including the Computerized Needs-Oriented Quality Measurement Evaluation System (CONQUEST), the Expansion of Quality of Care Measures (Q-SPAN) project, the Quality Measurement Network (QMNet) project, and the Performance Measures Inventory”

Some limitations are that it does not include ALL measures we are interested in, including rural measures and others that MMA identified and the University determined are unique. The clearinghouse does not include application and relevance to Minnesota providers.

The following is a table which provides a description of the information included in the NQMC for each measure.

### Complete Summary of NQMC Measure Attributes

<b>Title</b>	<b>Identifies the title of the measure.</b>	
<b>Source(s)</b>	Identifies the complete bibliographic source(s) for the measure as disseminated by the measure submitter(s).	
<b>Primary Measure Domain</b>	Classifies the major focus of the measure by one of the domains of care.	Choose one: <ul style="list-style-type: none"> <li>• Access</li> <li>• Outcome</li> <li>• Patient Experience</li> <li>• Population Health</li> <li>• Process</li> <li>• Structure</li> <li>• Use of Services</li> </ul>
<b>Secondary Measure Domain</b>	Identifies the secondary focus of the measure by domain of care (if applicable).  <i>Does not apply to Use of Services and Population Health measures.</i>	Choose all that apply: <ul style="list-style-type: none"> <li>• Access</li> <li>• Outcome</li> <li>• Patient Experience</li> <li>• Process</li> <li>• Structure</li> </ul>
<b>Brief Abstract</b>		
<b>Description</b>	Provides a concise statement of the specific aspects of health care, the patient population, providers, setting(s) of care, and time period that the measure addresses.	
<b>Rationale</b>	Identifies the rationale that briefly explains the importance of the measure (i.e., why it is used).	
<b>Primary Clinical Component</b>	Identifies the clinical aspect to which the measure refers, such as a structural feature, a clinical condition, a clinical process, a health outcome, and/or a patient characteristic. A combination of components may be identified (e.g., colorectal cancer; screening).	
<b>Denominator Description</b>	Provides the <i>general</i> specifications of any clinical component that is the	

<b>Title</b>	<b>Identifies the title of the measure.</b>	
	basis for inclusions and exclusions in the denominator.	
Numerator Description	Provides the <i>general</i> specifications of any clinical component that is the basis for inclusions and exclusions in the numerator.	
Evidence Supporting the Measure		
Evidence Supporting the Criterion of Quality	<p>Describes the type(s) of supporting evidence appropriate for the measure domain.</p> <ul style="list-style-type: none"> <li>• For access measures, evidence that an association exists between the result of the access measure and the outcomes of, or satisfaction with, care.</li> <li>• For outcome measures, evidence that the outcome measure has been used to detect the impact of one or more clinical interventions.</li> <li>• For patient experience measures, evidence that an association exists between the measure of patient experience of health care and the values and preferences of individuals/the public.</li> <li>• For process measures, evidence that the measured clinical process has led to improved health outcomes.</li> <li>• For structure measures, evidence that an association exists between the structure measure and one of the four other domains of quality (e.g., access, outcome, patient experience, and process).</li> </ul> <p>Type of evidence includes published peer-reviewed studies, systematic reviews, and clinical practice guidelines, formal consensus procedures involving experts in relevant clinical, methodological, and organizational sciences. For patient experience measures, evidence should include focus groups involving</p>	<p>Choose all that apply:</p> <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• A clinical practice guideline or other peer-reviewed synthesis of the clinical evidence</li> <li>• A formal consensus procedure, involving experts in relevant clinical, methodological, and organizational sciences</li> <li>• A systematic review of the clinical literature (e.g., Cochrane Review)</li> <li>• Focus groups</li> <li>• One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal</li> </ul>

Title	Identifies the title of the measure.	
	<p>patients and/or cognitive testing of the measure by patients. For access and structure measures, the consensus panel should also include other relevant stakeholders.</p> <p><i>Does not apply to Population Health and Use of Services measures.</i></p>	
Evidence Supporting the Value of Monitoring the Aspect of Population Health	<p>Describes the supporting evidence, if provided, for Population Health measures.</p> <p><i>Does not apply to Access, Outcome, Patient Experience, Process, Structure or Use of Services measures.</i></p>	<p>Choose all that apply:</p> <ul style="list-style-type: none"> <li>• No evidence is provided</li> <li>• A clinical practice guideline or other peer-reviewed synthesis of the clinical evidence</li> <li>• A formal consensus procedure, involving experts in relevant clinical, methodological, and organizational sciences</li> <li>• A systematic review of the clinical literature (e.g., Cochrane Review)</li> <li>• One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal</li> </ul>
Evidence Supporting the Value of Monitoring Use of Service	<p>Describes the supporting evidence if provided for Use of Services measures.</p> <p><i>Does not apply to Access, Outcome, Patient Experience, Population Health, Process, or Structure measures.</i></p>	<p>Choose all that apply:</p> <ul style="list-style-type: none"> <li>• No evidence is provided</li> <li>• A clinical practice guideline or other peer-reviewed synthesis of the clinical evidence</li> <li>• A formal consensus procedure, involving experts in relevant clinical, methodological, and organizational sciences</li> <li>• A systematic review of the clinical literature (e.g., Cochrane Review)</li> <li>• One or more research studies published in a National Library of Medicine (NLM) indexed,</li> </ul>

<b>Title</b>	<b>Identifies the title of the measure.</b>	
		peer-reviewed journal
<b>National Guideline Clearinghouse Link</b>	Identifies link(s) to guideline summary(s) in the National Guideline Clearinghouse™ (NGC) where the measure was developed from an evidence-based guideline.	
<b>Need for the Measure</b>	Describes the type(s) of evidence that supports the need for the measure (i.e., why this measure was selected by the submitter).	Choose all that apply: <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Overall poor quality for the performance measured</li> <li>• Use of this measure to improve performance</li> <li>• Variation in quality for the performance measured</li> </ul>
	For Structure measures	Choose all that apply: <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Overall insufficient capacity</li> <li>• Use of this measure to increase capacity</li> <li>• Variation in capacity</li> </ul>
	For Use of Services measures	Choose all that apply: <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Monitoring and planning</li> <li>• Variation in use of service</li> </ul>
	For Population Health measures	Choose all that apply: <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Monitoring health state(s)</li> <li>• Variation in health state(s)</li> </ul>
<b>Evidence Supporting Need for the Measure</b>	Identifies references that support the assertions made regarding the need for the measure.	
<b>State of Use</b>	Identifies the status of the measure regarding its use within the past three years by health care organizations. Measure use can encompass current routine use, pilot testing, or still in use by organizations/entities although discontinued by the measure developer.	Choose one: <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Current routine use</li> <li>• Pilot testing</li> <li>• Used, but developer discontinued</li> </ul>
<b>Current Use</b>	Classifies the current use(s) of the measure by quality initiative and constituency (e.g., Internal quality improvement, Decision-making by consumers about health plan/provider	Choose all that apply: <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Accreditation</li> <li>• Collaborative inter-organizational quality</li> </ul>

Title	Identifies the title of the measure.	
	<p>choice).</p> <p><i>The values "Internal quality improvement," "Collaborative inter-organizational quality improvement," "Quality of care research," "Decision-making by businesses about health-plan purchasing," "Decision-making by consumers about health plan/provider choice," and "Decision-making by health plans about provider contracting" may not be selected for Use of Services and Population Health measures.</i></p>	<p>improvement</p> <ul style="list-style-type: none"> <li>• Decision-making by businesses about health-plan purchasing</li> <li>• Decision-making by consumers about health plan/provider choice</li> <li>• Decision-making by health plans about provider contracting</li> <li>• Decision-making by managers about resource allocation</li> <li>• External oversight/Department of Defense/TRICARE</li> <li>• External oversight/Indian Health Service</li> <li>• External oversight/Maternal and Child Health Bureau</li> <li>• External oversight/Medicaid</li> <li>• External oversight/Medicare</li> <li>• External oversight/Prison health care systems</li> <li>• External oversight/Regional, county, or city agencies</li> <li>• External oversight/State government program</li> <li>• External oversight/Veterans Health Administration</li> <li>• Federal health policymaking</li> <li>• Internal quality improvement</li> <li>• Monitoring and planning</li> <li>• Monitoring health state(s)</li> <li>• National reporting</li> <li>• Pay-for-performance</li> <li>• Quality of care research</li> </ul>

Title	Identifies the title of the measure.	
		<ul style="list-style-type: none"> <li>• State health policymaking</li> </ul>
Application of the Measure in its Current Use		
<b>Care Setting</b>	Classifies the settings for which the measure applies.	Choose all that apply: <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Ambulatory Care</li> <li>• Ancillary Services</li> <li>• Behavioral Health Care</li> <li>• Community Health Care</li> <li>• Emergency Medical Services</li> <li>• Home Care</li> <li>• Hospices</li> <li>• Hospitals</li> <li>• Long-term Care Facilities</li> <li>• Managed Care Plans</li> <li>• Physician Group Practices/Clinics</li> <li>• Rehabilitation Centers</li> <li>• Residential Care Facilities</li> <li>• Rural Health Care</li> <li>• Substance Use Treatment Programs/Centers</li> </ul>
<b>Professionals Responsible for Health Care</b>	Classifies the professional(s) who is/are responsible for health care.  <i>For all area health indicators, the value "Public Health Professionals" must be selected.</i>	Choose all that apply: <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Advanced Practice Nurses</li> <li>• Allied Health Personnel</li> <li>• Chiropractors</li> <li>• Clinical Laboratory Personnel</li> <li>• Dentists</li> <li>• Dietitians</li> <li>• Emergency Medical Technicians/Paramedics</li> <li>• Measure is not provider specific</li> <li>• Nurses</li> <li>• Occupational Therapists</li> <li>• Pharmacists</li> <li>• Physical Therapists</li> <li>• Physician Assistants</li> <li>• Physicians</li> <li>• Podiatrists</li> <li>• Psychologists/Non-</li> </ul>



Title	Identifies the title of the measure.	
		physician behavioral Health Clinicians <ul style="list-style-type: none"> <li>• Public Health Professionals</li> <li>• Respiratory Care Practitioners</li> <li>• Social Workers</li> <li>• Speech-language Pathologists</li> </ul>
<b>Lowest Level of Health Care Delivery Addressed</b>	Classifies the most discrete level of health care delivery to which the measure (in its current use) applies.	Choose one: <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• National</li> <li>• Regional</li> <li>• States</li> <li>• Counties or Cities</li> <li>• Metropolitan Statistical Areas/Health Services Areas</li> <li>• Multisite Health Care Organizations</li> <li>• Single Health Care Delivery Organizations</li> <li>• Group Clinical Practices</li> <li>• Individual Clinicians</li> </ul>
<b>Target Population Age</b>	Describes the age range for the population measured.  <i>Does not apply to Structure measures.</i>	
<b>Target Population Gender</b>	Classifies the target population by gender.  <i>Does not apply to Structure measures.</i>	
<b>Stratification by Vulnerable Populations</b>	Describes the populations vulnerable to health care quality problems that are separately identified for sampling (e.g., Children, Homeless, Medically Uninsured).  <i>Does not apply to Structure measures.</i>	
<b>Incidence/Prevalence</b>	Describes the occurrence in a population of the disease or condition or the structural feature associated with the primary clinical component.	
<b>Evidence for Incidence/Prevalence</b>	Identifies references documenting information provided in the Incidence/Prevalence field.	
<b>Association with Vulnerable Populations</b>	Describes the association of the primary clinical component within a population vulnerable to health care quality problems.	
<b>Evidence for Association with Vulnerable Populations</b>	Identifies references documenting information provided in the Association with Vulnerable Populations field.	

<b>Title</b>	<b>Identifies the title of the measure.</b>	
<b>Burden of Illness</b>	Describes the time course and amount of disability associated with the primary clinical component.	
<b>Evidence for Burden of Illness</b>	Identifies references documenting information provided in the Burden of Illness field.	
<b>Utilization</b>	Describes the utilization of resources due to the primary clinical component that may include hospital days, admissions/discharges, ambulatory care visits, tests, and procedures.	
<b>Evidence for Utilization</b>	Identifies references documenting information provided in the Utilization field.	
<b>Costs</b>	Describes the costs associated with the primary clinical component that may include per diem costs, or the cost of ambulatory care visits, tests, and procedures. In cases where costs for these items are not known, but charges are used as a proxy for cost.	
<b>Evidence for Costs</b>	Identifies references documenting information provided in the Costs field.	
Institute of Medicine National Health Care Quality Report Categories		
<b>IOM Care Need</b>	<p>Classifies the measure into one of four Institute of Medicine (IOM) care need classifications where applicable.</p> <p><i>Structure and Use of Services measures will always have the value "Not within an IOM Care Need."</i></p>	<p>Choose all that apply to the primary clinical component:</p> <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Not within an IOM Care Need</li> <li>• End of Life Care</li> <li>• Getting Better</li> <li>• Living with Illness</li> <li>• Staying Healthy</li> </ul>
<b>IOM Domain</b>	<p>Classifies the measure into one or more of the Institute of Medicine (IOM) care domains where applicable.</p> <p><i>Structure and Use of Services measures will always have the value "Not within an IOM Domain."</i></p> <p><i>The IOM Domain "Efficiency" can only be selected in conjunction with one of the other IOM Domains.</i></p>	<p>Choose all that apply:</p> <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Not within an IOM Domain</li> <li>• Effectiveness</li> <li>• Efficiency</li> <li>• Equity</li> <li>• Patient-centeredness</li> <li>• Safety</li> <li>• Timeliness</li> </ul>
<b>Case Finding</b>	<p>Characterizes patients eligible for inclusion in the measure as users and/or nonusers of care.</p> <p><i>Does not apply to Structure measures.</i></p>	<p>Choose one:</p> <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Does not apply to this measure</li> <li>• Both users and nonusers of care</li> <li>• Users of care only</li> </ul>
<b>Description of Case Finding</b>	Describes the procedure for determining whether a case is potentially eligible for inclusion in the denominator of a measure. Case finding establishes a	

<b>Title</b>	<b>Identifies the title of the measure.</b>	
	sampling frame from which a more highly specified selection of cases will be made.  <i>Does not apply to Structure measures.</i>	
<b>Denominator Sampling Frame</b>	Classifies the cases <i>potentially</i> eligible for inclusion in the denominator, from which a more highly specified selection of cases will be made.  <i>Does not apply to Structure measures.</i>	Choose one: <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Does not apply to this measure</li> <li>• Enrollees or beneficiaries</li> <li>• Geographically defined</li> <li>• Organizationally defined</li> <li>• Patients associated with provider</li> </ul>
<b>Denominator Inclusions/Exclusions</b>	Describes the specific inclusion and exclusion criteria used to refine the denominator.	
Relationship of Denominator to Numerator	Designates whether all cases in the denominator are equally eligible to appear in the numerator.  <i>Does not apply to Structure measures.</i>  <i>Only the value "All cases in the denominator are not equally eligible to appear in the numerator" can be selected for Population Health measures.</i>  <i>The value "Unspecified" cannot be selected for Access, Outcome, Patient Experience, Process, or Structure measures.</i>	Choose one: <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Does not apply to this measure</li> <li>• All cases in the denominator are equally eligible to appear in the numerator</li> <li>• All cases in the denominator are not equally eligible to appear in the numerator</li> </ul>
<b>Denominator (Index) Event</b>	Identifies the event or state that defines a patient as eligible for inclusion in the denominator.  <i>Does not apply to Structure measures.</i>	Choose all that apply: <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Does not apply to this measure</li> <li>• Clinical Condition</li> <li>• Diagnostic Evaluation</li> <li>• Encounter</li> <li>• Institutionalization</li> <li>• Patient Characteristic</li> <li>• Provider Characteristic</li> <li>• Therapeutic Intervention</li> </ul>
<b>Denominator Time Window</b>	Classifies the time period (in association with the denominator	Choose one: <ul style="list-style-type: none"> <li>• Unspecified</li> </ul>

<b>Title</b>	<b>Identifies the title of the measure.</b>	
	<p>[index] event) in which patients are reviewed for inclusion in the denominator.</p> <p><i>Does not apply to Structure measures.</i></p>	<ul style="list-style-type: none"> <li>• Does not apply to this measure</li> <li>• Time window brackets index event</li> <li>• Time window follows index event</li> <li>• Time window is a fixed period of time</li> <li>• Time window is a single point in time</li> <li>• Time window precedes index event</li> </ul>
<b>Numerator Inclusions/Exclusions</b>	<p>Describes the specific inclusion and exclusion criteria used to refine the numerator.</p> <p>This field will be used to further describe the metric (if necessary).</p>	
<p>Measure Results Under Control of Health Care Professionals, Organizations and/or Policymakers</p>	<p>Designates whether measure results are somewhat or substantially under the control of the health care professionals, organizations and policymakers to whom the measure applies.</p> <p><i>The value "Unspecified" cannot be selected for Access, Outcome, Patient Experience, Process, or Structure measures.</i></p>	<p>Choose one:</p> <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.</li> <li>• The measure results are not under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.</li> </ul>
<b>Numerator Time Window</b>	<p>Identifies the time period in which patients are reviewed for inclusion in the numerator.</p>	<p>Choose one:</p> <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Does not apply to this measure</li> <li>• Encounter or point in time</li> <li>• Episode of care</li> <li>• Fixed time period</li> <li>• Institutionalization</li> </ul>
Data Source	<p>Identifies the data source(s) necessary to implement the measure.</p>	<p>Choose all that apply:</p> <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Administrative and laboratory data</li> </ul>

<b>Title</b>	<b>Identifies the title of the measure.</b>	
		<ul style="list-style-type: none"> <li>• Administrative and medical records data</li> <li>• Administrative and pharmacy data</li> <li>• Administrative and provider data</li> <li>• Administrative data</li> <li>• Administrative data and clinician survey</li> <li>• Administrative data and patient survey</li> <li>• Clinician survey</li> <li>• Laboratory data</li> <li>• Medical record</li> <li>• National public health data</li> <li>• Patient survey</li> <li>• Pharmacy data</li> <li>• Provider data</li> <li>• Registry data</li> <li>• Special or unique data</li> <li>• State public health data</li> </ul>
	For Structure measures, the following are possible data sources:	<> <ul style="list-style-type: none"> <li>• Administrative data</li> <li>• Clinician survey</li> <li>• National public health data</li> <li>• Provider data</li> <li>• Special or unique data</li> <li>• State public health data</li> </ul>
<b>Level of Determination of Quality</b>	Identifies the level at which quality can be assessed, i.e., at the individual patient level or the aggregate patient level.  <i>Does not apply to Structure, Population Health, and Use of Services measures.</i>	Choose one: <ul style="list-style-type: none"> <li>• Does not apply to this measure</li> <li>• Individual Case</li> <li>• Not Individual Case</li> </ul>
<b>Outcome Type</b>	Classifies the type of outcome for Outcome measures.  <i>Applies only when "Outcome" is selected as a Primary or Secondary Measure Domain.</i>	Choose one: <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Does not apply to this measure</li> <li>• Adverse Outcome</li> <li>• Clinical Outcome</li> <li>• Functional Status</li> </ul>

<b>Title</b>	<b>Identifies the title of the measure.</b>	
		<ul style="list-style-type: none"> <li>• Health Risk State or Behavior</li> <li>• Proxy for Outcome</li> <li>• Quality of Life Measure</li> </ul>
<b>Type of Health State</b>	<p>Classifies the type of health state for Population Health measures.</p> <p><i>Applies only to Population Health measures.</i></p>	<p>Choose one:</p> <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Does not apply to this measure</li> <li>• Adverse Health State</li> <li>• Functional Status</li> <li>• Health Risk State or Behavior</li> <li>• Health State not otherwise specified</li> </ul>
<b>Pre-existing Instrument Used</b>	Identifies all pre-existing instruments, such as a standardized survey instrument, used in implementing the measure.	
Computation of the Measure		
<b>Scoring</b>	Identifies the method used to score the measure.	<p>Choose one:</p> <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Categorical Variable</li> <li>• Continuous Variable</li> <li>• Count</li> <li>• Frequency Distribution</li> <li>• Non-weighted Score/Composite/Scale</li> <li>• Rate</li> <li>• Ratio</li> <li>• Weighted Score/Composite/Scale</li> </ul>
<b>Interpretation of Score</b>	<p>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.</p> <p><i>Applies to Process, Outcome, Access, Experience, and Structure measures.</i></p>	<p>Choose one:</p> <ul style="list-style-type: none"> <li>• Better quality is associated with a higher score</li> <li>• Better quality is associated with a lower score</li> <li>• Better quality is associated with a score falling within a defined interval</li> <li>• Passing score defines better quality</li> </ul>
	Applies to Population Health measures.	<p>Choose one:</p> <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• A higher score is desirable</li> <li>• A lower score is desirable</li> </ul>

<b>Title</b>	<b>Identifies the title of the measure.</b>	
		<ul style="list-style-type: none"> <li>• A score falling within a defined interval is desirable</li> </ul>
	Applies to all Use of Services measures.	<ul style="list-style-type: none"> <li>• Undetermined</li> </ul>
<b>Allowance for Patient Factors</b>	<p>Identifies the type of analytic considerations made for the measure based on patient factors or characteristics.</p> <p><i>Does not apply to Structure measures.</i></p>	<p>Choose all that apply:</p> <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Does not apply to this measure</li> <li>• Analysis by high-risk subgroup (stratification on vulnerable populations)</li> <li>• Analysis by subgroup (stratification on patient factors, geographic factors, etc.)</li> <li>• Case-mix adjustment</li> <li>• Paired data at patient level</li> <li>• Risk adjustment devised specifically for this measure/condition</li> <li>• Risk adjustment method widely or commercially available</li> </ul>
<b>Description of Allowance for Patient Factors</b>	<p>Describes the analytic considerations made for the measure based on the patient factors and characteristics.</p> <p><i>This field will not display if either "Unspecified" or "Does not apply to this measure" is selected in the "Allowance for Patient Factors" field.</i></p>	
<b>Standard of Comparison</b>	<p>Classifies the type and time frame of the comparison according to whether the comparison is external (at a given point-in-time or of a time trend), internal or to a prescriptive standard.</p> <p><i>The specific nature of the "prescriptive standard" (e.g., "pass/fail") will be described in the corresponding text field.</i></p>	<p>Choose all that apply:</p> <ul style="list-style-type: none"> <li>• Unspecified</li> <li>• Does not apply to this measure</li> <li>• External comparison at a point in time</li> <li>• External comparison of time trends</li> <li>• Internal time comparison</li> <li>• Prescriptive standard</li> </ul>
<b>Prescriptive Standard</b>	<p>Describes the prescriptive standard(s) used for comparison of measure results.</p>	
<b>Evidence for Prescriptive Standard</b>	<p>Identifies references documenting information provided in the Prescriptive Standard field.</p>	

<b>Title</b>	<b>Identifies the title of the measure.</b>
	<i>Does not apply to Use of Services and Population Health measures.</i>
Evaluation of Measure Properties	
<b>Extent of Measure Testing</b>	Describes the extent of testing of the measure including reliability and/or validity testing.
<b>Evidence for Reliability/Validity Testing</b>	Identifies references documenting reliability/validity testing as described in the Extent of Measure Testing field.
<b>Original Title</b>	Identifies the original name of the measure as stated in the original measure documentation.
<b>Measure Collection</b>	Identifies the name of the collection of measures to which the measure belongs (if applicable).
<b>Measure Set Name</b>	Identifies the name of the measure set to which the measure belongs (if applicable).
<b>Measure Subset Name</b>	Identifies the name of the subset to which the measure belongs (if applicable).
<b>Composite Measure Name</b>	Identifies the name of the composite measure to which the measure belongs (if applicable).
<b>Submitter</b>	Identifies the organization(s) that submitted the measure to NQMC.
<b>Developer</b>	Identifies the organization(s) that developed the measure.
<b>Funding Source(s)</b>	Identifies source(s) of funding to the organization(s) for developing the measure(s) or measure set(s)/collection(s).
<b>Composition of the Group that Developed the Measure</b>	Describes the composition of the group/committee that developed the measure(s) or measure set(s)/collection(s), including professional degrees and affiliations, and lists the names of individual committee members, where given.
<b>Financial Disclosures/Other Potential Conflicts of interest</b>	Records and makes publically available disclosed relationships between individuals of the measure development committee/group/individual and companies or organizations that could potentially influence that individual's contribution to the development of the measure(s) or measure set(s)/collection(s).
<b>Endorser</b>	Identifies the organization(s) that have endorsed the measure.
<b>Included In</b>	Identifies the inclusion of a measure in specified measure initiatives (e.g., National Healthcare Quality Report (NHQR), National Healthcare Disparities Report (NHDR), Home Health Compare).
<b>Adaptation</b>	Identifies that the measure has been adapted <b>from</b> another measure(s).
<b>Parent Measure</b>	Identifies the name(s) of all the measures from which the current measure was adapted. The name of each "parent" measure's developer follows in parentheses.
<b>Release Date</b>	Identifies the date that the measure was first released by the submitting organization (this could be the date first issued or published).
<b>Revision Date</b>	Identifies the date of the most recent revision to the measure and/or the documentation by the submitting organization (if applicable).
<b>Measure Status</b>	Identifies whether the measure is the current release or an update.
<b>Source(s)</b>	Identifies the complete bibliographic source(s) for the measure as



<b>Title</b>	<b>Identifies the title of the measure.</b>
	disseminated by the measure submitter(s).
<b>Measure Availability</b>	Identifies contact information for requesting the measure documentation. Where possible, information regarding electronic (including hypertext links to the full-text) and print copies is provided.
<b>Companion Documents</b>	Identifies companion documents that are relevant to the measure. These companion documents are not necessarily available within NQMC.
<b>NQMC Status</b>	Identifies when the measure was completed or revised by ECRI, and verified by the submitting organization(s).
<b>Copyright Statement</b>	Provides the copyright statement of the organization that submitted the measure.
Disclaimer	

(Source: AHRQ)

For a complete listing of NQMC measures, see Attachment I. Because of the large number of measures, the list is quite long; however, it is a minimum data list including only the NQMC name of the measure and the initiative associated with the measure. The list can be scanned to find types of measures of interest. While connected to the internet and with an electronic version of the report, one can “Control click” on any of the measures to link to a “complete summary” of the measure. An example of a complete summary is provided below.

### Example: Complete Summary of a Measure

#### TITLE

**Health plan members' experiences: percentage of adult health plan members who reported how often their personal doctor communicated well.**

#### SOURCE(S)

- CAHPS® health plan survey and reporting kit 2007. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2006 Nov 14. Various p.
- CAHPS®: Surveys and tools to advance patient-centered care [https://www.cahps.ahrq.gov/default.asp]. [internet]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); [updated 2008 Feb 21]; [accessed 2007 Sep 05]. [3 p].

#### Measure Domain

##### PRIMARY MEASURE DOMAIN

Patient Experience

The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the [Measure Validity](#) page.

##### SECONDARY MEASURE DOMAIN

Does not apply to this measure

#### Brief Abstract

##### DESCRIPTION

This measure is used to assess the percentage of respondents who indicated how often ("Never," "Sometimes," "Usually," or "Always") their personal doctor:

- explained things in a way that was easy for them to understand.
- listened carefully to them.

- showed respect for what they had to say.
- spent enough time with them.

The "How Well Doctors Communicate" composite measure is based on four questions in the CAHPS Health Plan Survey 4.0 (Adult Questionnaire).

**Note:** A composite score is calculated in which a higher score indicates better quality. Composite scores are intended for consumer-level reporting. Additionally, frequency distributions are available for plans or providers to use for quality improvement purposes.

#### **RATIONALE**

The Agency for Healthcare Research and Quality (AHRQ) (then called the Agency for Health Care Policy and Research, or AHCPH) initiated the CAHPS program in October 1995 to develop standardized survey tools for obtaining and reporting information on consumers' experiences with health care. The CAHPS consortium began by developing the CAHPS Health Plan Survey, an integrated set of carefully tested and standardized questionnaires and report formats that can be used to produce meaningful, reliable, and comparable information about the experiences of consumers enrolled in health plans.

The CAHPS Health Plan Survey is designed to generate information that consumers can use to choose health plans, that purchasers can use to assess the value of services they buy, and that health plans can use to assess their performance and improve their products and services. As AHRQ had intended, the survey can be used with all types of health insurance consumers--including Medicaid recipients, Medicare beneficiaries, and those who are commercially insured--and across the full range of health care delivery systems, from fee-for-service to managed care plans. The instruments also capture information about special groups, including individuals with chronic conditions and disabilities and families with children.

The National Committee for Quality Assurance (NCQA) requires health plans to submit measures from the CAHPS Health Plan Survey as part of their HEDIS submission and for accreditation purposes.

#### **PRIMARY CLINICAL COMPONENT**

Health care; members' experiences; physician communication

#### **DENOMINATOR DESCRIPTION**

Health plan members age 18 years and older who answered the "How Well Doctors Communicate" questions on the CAHPS Health Plan Survey 4.0 (Adult Questionnaire) (see the "Description of Case Finding" and the "Denominator Inclusions/Exclusions" fields in the Complete Summary)

#### **NUMERATOR DESCRIPTION**

The number of "Never," "Sometimes," "Usually," or "Always" responses on the "How Well Doctors Communicate" questions (see the related "Numerator Inclusions/Exclusions" field in the Complete Summary)

#### **Evidence Supporting the Measure**

##### **EVIDENCE SUPPORTING THE CRITERION OF QUALITY**

A formal consensus procedure involving experts in relevant clinical, methodological, and organizational sciences

One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

#### **Evidence Supporting Need for the Measure**

##### **NEED FOR THE MEASURE**

- Use of this measure to improve performance
- Variation in quality for the performance measured

##### **EVIDENCE SUPPORTING NEED FOR THE MEASURE**

- What consumers say about the quality of their health plans and medical care: The National CAHPS Benchmarking Database. 2007 CAHPS health plan survey chartbook. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2007 Dec. 41 p.

#### **State of Use of the Measure**

##### **STATE OF USE**

Current routine use

**CURRENT USE**

Accreditation

Decision-making by businesses about health-plan purchasing

Decision-making by consumers about health plan/provider choice

External oversight/Department of Defense/TRICARE

External oversight/Medicaid

External oversight/Medicare

External oversight/State government program

Internal quality improvement

National reporting

Quality of care research

**Application of Measure in its Current Use**

**CARE SETTING**

Managed Care Plans

**PROFESSIONALS RESPONSIBLE FOR HEALTH CARE**

Physicians

**LOWEST LEVEL OF HEALTH CARE DELIVERY ADDRESSED**

Single Health Care Delivery Organizations

**TARGET POPULATION AGE**

Age greater than or equal to 18 years

**TARGET POPULATION GENDER**

Either male or female

**STRATIFICATION BY VULNERABLE POPULATIONS**

Unspecified

**Characteristics of the Primary Clinical Component**

**INCIDENCE/PREVALENCE**

Unspecified

**ASSOCIATION WITH VULNERABLE POPULATIONS**

Unspecified

**BURDEN OF ILLNESS**

Unspecified

**UTILIZATION**

Unspecified

**COSTS**

Unspecified

**Institute of Medicine National Healthcare Quality Report Categories**

**IOM CARE NEED**

End of Life Care

Getting Better

Living with Illness

Staying Healthy

**IOM DOMAIN**

Patient-centeredness

**Data Collection for the Measure**

**CASE FINDING**

Both users and nonusers of care

## **DESCRIPTION OF CASE FINDING**

Health plan members age 18 years and older, who have been enrolled in:

- the commercial plan for 12 months or longer, with no more than one 45-day break in enrollment during the 12 months

**OR**

- a Medicaid plan or product for 6 months or longer, with no more than one 30-day break in enrollment during the 6 months.

## **DENOMINATOR SAMPLING FRAME**

Enrollees or beneficiaries

## **DENOMINATOR INCLUSIONS/EXCLUSIONS**

### **Inclusions**

Health plan members age 18 years and older who answered the "How Well Doctors Communicate" questions on the CAHPS Health Plan Survey 4.0 (Adult Questionnaire). Include refusals, non-response, and bad addresses/phone numbers.

### **Exclusions**

- Individuals with coverage other than primary health coverage, such as a dental-only plan
- Deceased
- Ineligible (not enrolled in the plan)

## **RELATIONSHIP OF DENOMINATOR TO NUMERATOR**

All cases in the denominator are equally eligible to appear in the numerator

## **DENOMINATOR (INDEX) EVENT**

Patient Characteristic

## **DENOMINATOR TIME WINDOW**

Time window precedes index event

## **NUMERATOR INCLUSIONS/EXCLUSIONS**

### **Inclusions**

The number of "Never," "Sometimes," "Usually," or "Always" responses on the "How Well Doctors Communicate" questions

From the responses, a composite score is calculated in which a higher score indicates better quality.

**Note:** Include all completed questionnaires. A questionnaire is considered complete if responses are available for 10 or more of a selected list of key CAHPS items. Refer to the original measure documentation for more information.

### **Exclusions**

Unspecified

## **MEASURE RESULTS UNDER CONTROL OF HEALTH CARE PROFESSIONALS, ORGANIZATIONS AND/OR POLICYMAKERS**

The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.

## **NUMERATOR TIME WINDOW**

Fixed time period

## **DATA SOURCE**

Administrative data

Patient survey

## **LEVEL OF DETERMINATION OF QUALITY**

Not Individual Case

## **PRE-EXISTING INSTRUMENT USED**

Unspecified

## **Computation of the Measure**

## **SCORING**

Non-weighted Score/Composite/Scale

## **INTERPRETATION OF SCORE**

Better quality is associated with a higher score

## **ALLOWANCE FOR PATIENT FACTORS**

Analysis by subgroup (stratification on patient factors, geographic factors, etc.)

Case-mix adjustment

## **DESCRIPTION OF ALLOWANCE FOR PATIENT FACTORS**

CAHPS recommends adjusting the data for respondent age, education, and general health status.

If the sample size is sufficient, responses may be analyzed for specific sub-populations, such as respondents with chronic conditions.

## **STANDARD OF COMPARISON**

External comparison at a point in time

External comparison of time trends

Internal time comparison

## **Evaluation of Measure Properties**

### **EXTENT OF MEASURE TESTING**

The CAHPS Health Plan Survey has probably been tested more completely than any previously used consumer survey.

There are two different and complementary approaches to assessing the reliability and validity of a questionnaire (1) cognitive testing, which bases its assessments on feedback from interviews with people who are asked to react to the survey questions, and (2) psychometric testing, which bases its assessments on the analysis of data collected by using the questionnaire. Although many existing consumer questionnaires about health care have been tested primarily or exclusively using a psychometric approach, the CAHPS team views the combination of cognitive and psychometric approaches as essential to producing the best possible survey instruments. Consequently, both methods have been included in the development of the CAHPS survey. The cognitive testing method provided useful information on respondents' perceptions of the response task, how respondents recalled and reported events, and how they interpreted specified reference periods. It also helped identify words that could be used to describe health care providers accurately and consistently across a range of consumers (e.g., commercially insured, Medicaid, fee-for-service, managed care, lower socioeconomic status [SES], middle SES, low literacy, higher literacy) and helped explore whether key words and concepts included in the core questions worked equally well in both English and Spanish.

The CAHPS consortium also tested each CAHPS reporting composite in focus groups with plan members. Cognitive interviews with consumers were conducted to ensure that the reporting composites and their labels were easily understood. Psychometric analyses using data collected during pilot tests were also conducted. These analyses indicated that both the composites and the items in each composite were reliable and valid measures of members' experiences. In addition, items in each reporting composite were tested and found to be internally consistent. For example, reliability coefficients (Cronbach's alpha) in one pilot test involving four health plans using the instrument that most resembled the final CAHPS 2.0 instrument ranged from a low of 0.68 for the "Getting Needed Care" composite to a high of 0.90 for the "How Well Doctors Communicate" composite. These composites are positively associated with members' ratings of overall care provided by doctors and nurses and ratings of health plans.

In addition, the CAHPS development team, together with researchers from the National Committee on Quality Assurance (NCQA), conducted a detailed comparative analysis of the items in the CAHPS questionnaire and NCQA's Member Satisfaction Survey (MSS) from the fall of 1997 to the spring of 1998. These questionnaires were merged to form the 2.0 version of the CAHPS questionnaire. This testing is noteworthy because it was so extensive and because of the wide array of techniques used. These included focus groups, in-depth cognitive

testing, pilot studies, methodological experiments, and large demonstration studies, such as the demonstrations in Washington State, Kansas, and New Jersey. NCQA also worked with the CAHPS consortium to conduct field tests of the 4.0 instrument with six health plans in Spring 2005.

#### **EVIDENCE FOR RELIABILITY/VALIDITY TESTING**

- CAHPS®: Surveys and tools to advance patient-centered care [https://www.cahps.ahrq.gov/default.asp]. [internet]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); [updated 2008 Feb 21]; [accessed 2007 Sep 05]. [3 p].

### **Identifying Information**

#### **ORIGINAL TITLE**

How well doctors communicate.

#### **MEASURE COLLECTION**

[CAHPS Health Plan Survey](#)

#### **MEASURE SET NAME**

[CAHPS Health Plan Survey 4.0, Adult Questionnaire](#)

#### **SUBMITTER**

Agency for Healthcare Research and Quality

#### **DEVELOPER**

Agency for Healthcare Research and Quality

CAHPS Consortium

Centers for Medicare & Medicaid Services

#### **FUNDING SOURCE(S)**

Unspecified

#### **COMPOSITION OF THE GROUP THAT DEVELOPED THE MEASURE**

Unspecified

#### **FINANCIAL DISCLOSURES/OTHER POTENTIAL CONFLICTS OF INTEREST**

Unspecified

#### **ENDORSER**

National Quality Forum

#### **ADAPTATION**

Measure was not adapted from another source.

#### **RELEASE DATE**

1997 Mar

#### **REVISION DATE**

2006 Nov

#### **MEASURE STATUS**

This is the current release of the measure.

This measure updates a previous version: CAHPS® Health Plan Survey and Reporting Kit 2002 (3.0 Version). Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2002. This previous version of the CAHPS Health Plan Survey remains available for use through 2007. Therefore, NQMC will retain the [CAHPS Health Plan Survey 3.0 version](#) on the NQMC Web site.

#### **SOURCE(S)**

- CAHPS® health plan survey and reporting kit 2007. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2006 Nov 14. Various p.
- CAHPS®: Surveys and tools to advance patient-centered care [https://www.cahps.ahrq.gov/default.asp]. [internet]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); [updated 2008 Feb 21]; [accessed 2007 Sep 05]. [3 p].

#### **MEASURE AVAILABILITY**

The individual measure, "How Well Doctors Communicate," is published in the "CAHPS Health Plan Survey and Reporting Kit 2007." This Kit may be downloaded at the [CAHPS Survey Users Network Web site](#). See the related [QualityTools](#) summary.

#### **COMPANION DOCUMENTS**

The following are available:

- What consumers say about the quality of their health plans and medical care: The National CAHPS Benchmarking Database. 2007 CAHPS health plan survey chartbook. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2007 Dec. 41 p. This document is available in Portable Document Format (PDF) from the [CAHPS Web site](#). See the related [QualityTools](#) summary.
- CAHPS user resources: project implementation resources. [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); [updated 2005 Dec 29]; [accessed 2007 Jan 25]. Available from the [CAHPS Web site](#).
- CAHPS community: the report card compendium. [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); [updated 2006 Nov 14]; [accessed 2007 Jan 25]. Available from the [CAHPS Web site](#).  
CAHPS survey and reporting kits. Project profiles. [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); [updated 2007 Feb 5]; [accessed 2007 Jan 25]. Available from the [CAHPS Web site](#).
- CAHPS survey and reporting kits. Reporting resources: downloadable documents. [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); [updated 2007 Jun 12]; [accessed 2007 Jan 25]. Available from the [CAHPS Web site](#).
- Edgman-Levitan S, Shaller D, McInnes K, Joyce R, Coltin KL, Cleary PD, Rybowski L, editor(s). The CAHPS improvement guide. Practical strategies for improving the patient care experience. Cambridge (MA): Department of Health Care Policy, Harvard Medical School; 2003 Oct 1. 156 p. This document is available in (PDF) from the [CAHPS Web site](#).

#### **NQMC STATUS**

This NQMC summary was completed by ECRI on April 24, 2007. The information was verified by the measure developer on June 15, 2007.

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(Source: AHRQ)

### Conducting Measure Searches and Measure Comparisons Using the NQMC Data Base

NQMC will be updated continuously and accepts submission of new measures from many sources. There are numerous ways to search and select on measures for comparison. A tutorial is offered to assist users in techniques for searching the stat base.

See Appendix A for three examples of searches:

- 1) Diabetes nephropathy measures
- 2) Diabetes measures for 13-18 year olds
- 3) Cardiologist measures

## **Section IV: Measures of Interest Not Found in the NQMC**

We cross-referenced measures reported from a large number of state and national sources to identify any unique measures that were not among the vast number included in the NQMC. We found a relatively small set. In some cases, the measure was listed as unique if it broke down the NQMC related measure into more detailed sub-categories. The example of this reported below is the set measures related to antibiotic use for surgery. Stratis Health-reported measures define the measure for each of a number specific types of surgery; whereas NQMC includes the same measure but primarily aggregates across types of surgery. Because some Minnesota hospitals use the surgery type-specific measures, they are considered unique and relevant. For other measures, namely the rural hospital measures and a set of detailed functional status measures for home health care reported below, the measures themselves are unique and, again, relevant for Minnesota. These measures are not repeated in the next section where we report on additional measures in use in Minnesota whether unique or included in the NQMC.

### **Unique Measures (Source: Stratis Health)**

#### **Rural Hospital Measures**

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Prescribing Practices	Read back verbal orders
	Admission orders reconciled with home meds
	Review of order by pharmacist within 24 hours
	Pharmacist rounds with physicians
Documenting Practices	Handwritten MAR
	Electronic MAR from pharmacy software
	MAR verified against order before drug prep
Medication Acquisition Practices	RN/LPN responsible for obtaining new medications (M-F Day)
	RN/LPN responsible for obtaining new medications (Weekend Day)
	RN/LPN responsible for obtaining new medications (M-F Night)
	Independent double check in pharmacy (M-F Day)
	Majority of oral medications in unit dose form
Administering Practices	Automated dispensing cabinet in use
	Meds routinely selected/administered by same person
	Two identifiers (excluding room no.) used to establish patient identity
	Unopened unit dose verified with MAR at bed
Medication Error Reporting Practices	Error reports NOT placed in personnel files
	NCC MERP taxonomy used to categorize error severity
	Near misses routinely reported
	Medication errors discussed at medication safety committee
Safe Culture Practices	Conducted root cause analysis within the last year
	Aggregate medication error data compared to external database
	Aggregate medication error data shared with hospitals of similar size



	Survey of patient safety culture conducted in the past year	
	Harmful errors disclosed to patients/families	
	Accredited by JCAHO	
Pharmacist Support	Pharmacist employed by hospital	
	Pharmacist onsite 5 or fewer hours per week	
	Contract with local community pharmacist	
	Current pharmacy vacancy	
	Report they lack patient volume to support full time pharmacist	
	Limited financial resources	
	Shortage of pharmacists	
	Stakeholders disagree concerning need for pharmacy report	
Emergency Department Chest Pain/AMI Assessment Measures	Time to ECG	Time of arrival at ED until time of first 12 lead ECG. Includes pre-hospital ECG at 0 minutes. ACC and AHA standard of 10 minutes is used for the standard
	Aspirin within 24 hours	Proportion of CP/AMI patients in the ED without aspirin contraindications who received aspirin within 24 hours before or after hospital arrival
Emergency Department Trauma Vital Signs Measure	Time to Thrombolytics	Proportion of ED AMI patients with ST elevation on ECG whose time from hospital arrival to thrombolysis is 30 minutes or less
	Emergency Department Trauma Vital Signs	Proportion of trauma patients with systolic blood pressure, pulse rate, or respiratory rate documented on arrival to the ED and at least hourly (or until ER patient is released, admitted or transferred).
Emergency Department transfer time and communication	ED transfer time and communication	Number of information elements sent with transfer patients in 7 categories (pre-transfer communication, patient identification, vital signs, medication - related information, physician generated information, nurse generated information, and procedures and tests).
Emergency Department transfer time and communication	Patient Time in ED (longer than 2 hours)	
	Patient Time in ED (longer than 4 hours)	
	Condition Categories:	
	Brain injured	
	Burns	
	Crushing Injury	
	Foreign body	
	Fracture	
	Internal injury	
	Open wounds	
	Arrived by Ambulance	
	Discharge Status	
	Admitted to this hospital	
	Discharged to home	
	Discharged to ICF	
Emergency Department Transfer Communication Measure	Left AMA	
	ED transfer communication	
	Transferred to short term general hospital	
	Administrative information:	
	1. Nurse communication with receiving hospital staff	
	2. Physician communication with receiving professional staff	
	Patient information	

1. Name
2. Address
3. Age
4. Gender
5. Contact information for significant others
6. Insurance information

Vital Signs

1. Pulse
2. Respiration
3. Blood Pressure
4. Temperature
5. Oxygen level
6. Glasgow score
7. Apgar score

Medication communication

1. Medication history
2. Medications given (MAR)
3. Allergies

Physician documentation

1. Physician's history and physical
2. Physician's orders and reason for transfer

Nurse documentation

1. Nurse documentation: interventions/response to care
2. Impairments
3. Immobility
4. Respiratory support given
5. Oral restriction
6. Catheters

Tests and procedures

1. Tests and procedures done
2. Tests and procedures sent

## Home Health Measures

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OBQI

Outcome  
Measures

Outcome Measures

- Improvement in grooming
- Stabilization in grooming
- Improvement in dressing upper body
- Improvement in dressing lower body
- Improvement in bathing
- Stabilization in bathing

Improvement in toileting  
 Improvement in transferring  
 Stabilization in transferring  
 Improvement in ambulation  
 Improvement in eating  
 Improvement in light meal preparation  
 Stabilization in light meal preparation  
 Improvement in laundry  
 Stabilization in laundry  
 Improvement in housekeeping  
 Stabilization in housekeeping  
 Improvement in shopping  
 Stabilization in shopping  
 Improvement in phone use  
 Stabilization in phone use  
 Improvement in management of oral meds  
 Stabilization in management of oral meds  
 Improvement in speech and language  
 Stabilization in speech and language  
 Improvement in pain interfering w/ activity  
 Improvement in number of surgical wounds  
 Improvement in status surgical wounds  
 Improvement in dyspnea  
 Improvement in urinary tract infection  
 Improvement in urinary incontinence  
 Improvement in bowel incontinence  
 Improvement in cognitive functioning  
 Stabilization in cognitive functioning  
 Improvement confusion frequency  
 Improvement in anxiety level  
 Stabilization in anxiety level  
 Improvement in behavioral problem frequency  
 Any emergent care  
 Utilization Measures  
 Discharge to the Community  
 Acute care hospitalization

### Additional Unique Measures (Source: Stratis Health)

Domain	Measure	Description
Outpatient (AMI) and Chest Pain	OP-5	Median Time to ECG
AMI	AMI-3	ACEI or ARB for LVSD
AMI	AMI-8	Median Time to Primary PCI

AMI	AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival
AMI	AMI-9	Inpatient Mortality
AMI	AMI-T1a	LDL-Cholesterol Assessment (Optional Test Measure)
AMI	AMI-T2	Lipid-Lowering Therapy at Discharge (Optional Test Measure)
HF	HF-2	Evaluation of LVS Function
PN	PN-6a	Initial Antibiotic Selection for CAP in Immunocompetent – ICU Patient
PN	PN-6b	Initial Antibiotic Selection for CAP Immunocompetent – Non ICU Patient
SCIP	SCIP-Inf-1a	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision - Overall Rate
SCIP	SCIP-Inf-1b	CABG
SCIP	SCIP-Inf-1c	Other Cardiac Surgery
SCIP	SCIP-Inf-1d	Hip Arthroplasty
SCIP	SCIP-Inf-1e	Knee Arthroplasty
SCIP	SCIP-Inf-1f	Colon Surgery
SCIP	SCIP-Inf-1g	Hysterectomy
SCIP	SCIP-Inf-1h	Vascular Surgery
SCIP	SCIP-Inf-2a	Prophylactic Antibiotic Selection for Surgical Patients - Overall Rate
SCIP	SCIP-Inf-2b	CABG
SCIP	SCIP-Inf-2c	Other Cardiac Surgery
SCIP	SCIP-Inf-2d	Hip Arthroplasty
SCIP	SCIP-Inf-2e	Knee Arthroplasty
SCIP	SCIP-Inf-2f	Colon Surgery
SCIP	SCIP-Inf-2g	Hysterectomy
SCIP	SCIP-Inf-2h	Vascular Surgery
SCIP	SCIP-Inf-7	Colorectal Surgery Patients with Immediate Postoperative Normothermia
SCIP	SCIP-Card-2	Surgery Patients on Beta-Blocker Prior to Arrival /Received a Beta-Blocker Perioperative
SCIP	SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
SCIP	SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours Prior to Surgery to 24 Hours After Surgery
PR	PR-1	VBAC
PR	PR-3	Third or Fourth Degree Laceration
CAC	CAC-1b	Relievers for Inpatient Asthma (age 2 through 4 years)
CAC	CAC-1c	Relievers for Inpatient Asthma (age 5 through 12 years)
CAC	CAC-1d	Relievers for Inpatient Asthma (age 13 through 17 years)
CAC	CAC-2a	Systemic Corticosteroids for Inpatient Asthma (age 2 through 17 years) – Overall Rate
CAC	CAC-2b	Systemic Corticosteroids for Inpatient Asthma (age 2 through 4 years)
CAC	CAC-2c	Systemic Corticosteroids for Inpatient Asthma (age 5 through 12 years)
CAC	CAC-2d	Systemic Corticosteroids for Inpatient Asthma (age 13 through 17 years)
CAC	CAC-3	Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver

## **Section V – Measures in Use in Minnesota**

Minnesota has long been a pioneer in the development and implementation of quality measures for quality improvement and public reporting. Health plans were using claims

data to assess physician practice breast cancer screening rates as early as 1988. These efforts preceded NCQA and other national efforts. In fact, Minnesota health plans have been at the forefront of quality measurement activities nationally. In addition, Minnesota health plans and purchasers have collaborated to develop standards for assessing and reporting. The most recent and successful of these is the Minnesota Community Measurement organization that has become a national leader in collaborative measurement of physician quality performance and is extending its work beyond both health plans and claims data as part of the RWJ Aligning Forces for Quality program and related direct data submissions from physician practices. MNCM also supports the implementation of the Bridges to Excellence program in the State.

Another collaborative that has produced measures to support the implementation of evidence-based guidelines in the region is the Institute for Clinical Systems Improvement (ICSI). ICSI has developed a number of measures associated with monitoring adherence with ICSI guidelines. These measures have influenced national efforts and have been used to adapt national measures for regional use.

Stratis Health is also an innovative quality performance and management organization that serves as the QIO for the region. Stratis Health and the Minnesota Hospital Association came together in 2005 to launch the Minnesota Hospital Quality Report. This web-based report card includes measures of clinical care in heart failure, pneumonia, heart attack, and surgical care, including the innovative Appropriate Care Measure, a patient-focused measure that provides a way of looking at whether a patient received ALL of the “appropriate” or “right care” (recommended treatments) that they should have received, based on their clinical condition. The report recently added a measure of patients’ experiences in the hospital, as assessed by HCAHPS.

Stratis Health completed in 2005 the Rural Measures Special Study for the Federal Centers for Medicare & Medicaid Services, through which Stratis Health led a multi-state field test of new rural-relevant hospital emergency department measures, and facilitated a national technical Expert Panel, resulting in recommendations to CMS that were enacted in the 2008 Outpatient Prospective Payment System.

In addition, health plans have adapted quality measures or developed new measures for their pay-for-performance programs. With this history of quality measurement and collaboration, Minnesota is well positioned to continue the advancement of quality performance measurement of physician practices and hospitals over the next few years to achieve a community-wide, all-payer standard for performance assessment and reporting.

Currently, nursing homes and home health agencies are reporting quality performance information for the Medicare Home Health and Nursing Home Compare programs. Additional quality assessment of nursing homes and hospitals is also being conducted. Hospitals in the state are likewise reporting quality performance information for the Medicare Hospital Compare program. Critical-access hospitals (CAHs) and other hospitals previously not permitted to report their outpatient quality information will soon be able to do so. In addition, Minnesota Hospital Association and the Minnesota

Department of Health are sponsoring an adverse event reporting initiative that also includes developing and adopting protocols for reducing adverse events. The four adverse events being reported for improvement include: wrong body part surgery, retained foreign objects, falls, and pressure ulcers. The Minnesota Hospital Association is also participating in an Agency for Healthcare Research and Quality sponsored two-year project that allows clinical lab data to be paired with administrative billing data.

MHA reports that, “Hospitals already submit billing data to MHA. Any hospital can be part of this new initiative by agreeing to also submit their clinical lab data. Once the new lab data and billing data are merged, a more sophisticated severity adjustment system can be applied, and hospital performance on quality and patient safety measures can be more accurately analyzed. The new merged data will also help hospitals double-check their accuracy for coding conditions present on admission.”

The longest standing and most developed public reporting has been of health plans initially and now physician practices - particularly in primary care. While physician practice level quality performance reporting has been well underway in Minnesota, Medicare has only recently implemented its voluntary Physician Quality Reporting Initiative (PQRI) which advances Medicare plans to implement public reporting and pay-for-performance for physician practices. Physician practices have been the primary component of the health care delivery system being assessed by MN Community Measurement, health plans, and purchasers. The Minnesota Medical Association has compiled an inventory of quality measures being used in Minnesota for pay-for-performance and other measurement purpose. The following table is a summary table of measures that was updated in 2008. Additional MMA tables provide extensive detail about the measures.

**Minnesota Medical Association Measure Summary**  
(\*Indicates measure is included in the NQMC)

Measure	BCBS MN 2008 Recognizing	Bridges to Excellence 2007-2008	HealthPartners Partners in Progress	HealthPartners Partners in Excellence	Medica Performance -Based	Medica Choice Care Quality	Preferred One Updated	UCare P4P program Updated	DHS Reporting requirements	QCare	MN Community Measurement	2008 CMS PQRI Updated
1. Acute Bronchitis*												x
2. Advanced Care Plan*												x
3. Asthma	x						x				x	x
4. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*							x				x	
5. Board Maintenance of Certification	x											
6. Body mass index (BMI) and weight management plan*	x		x	x								x
7. Cancer – Breast Cancer*												X
8. Cancer – Chemotherapy plan*												x

Measure	BCBS MN 2008 Recognizing	Bridges to Excellence 2007-2008	HealthPartne rs Partners in Progress	HealthPartne rs Partners in Excellence	Medica Performance -Based	Medica Choice Care Quality	Preferred One Updated	UCare P4P program Updated	DHS Reporting requirements	QCare	MN Community Measurement	2008 CMS PQRI Updated
9. Cancer – Chemotherapy for colon cancer*												x
10. Cancer – Chronic Lymphocytic Leukemia*												x
11. Cancer – Multiple Myeloma*												x
12. Cancer - Myelodysplastic Syndrome (MDS) and Acute Leukemias*												x
13. Cancer – Prostate Cancer*												x
14. Cardiovascular - Acute Myocardial Infarction*										x		x
15. Cardiovascular – Non-traumatic Chest pain*												x
16. Cardiovascular - Congestive Heart Failure*	x									x		x
17. Cardiovascular - Congestive heart failure program*			x	x								
18. Cardiovascular – Coronary Artery Bypass Graph*												x
19. Cardiovascular – Coronary Artery Disease (Optimal cardiac care)*	x	x		x	x		x	x	x	x	x	x
20. Cardiovascular - Recurrent atrial Fibrillation*	x											
21. Carpal tunnel release			x									
22. Child and teen check up								x				
23. Child developmental screening incentive*									x			
24. Child mental health screening incentive									x			
25. Chronic Kidney Disease*												x
26. Chronic Obstructive Pulmonary Disease (COPD)*												x
27. Community Acquired Bacterial Pneumonia*												x
28. Critical Care												x
29. Depression Care*	x	x		x			x				x	x
30. Depression Symptom Assessment tool*			x									
31. Diabetes*	x	x		x	x	x	x	x	x	x	x	x
32. Discectomy for acute disc herniation			x									

Measure	BCBS MN 2008 Recognizing	Bridges to Excellence 2007-2008	HealthPartners Partners in Progress	HealthPartners Partners in Excellence	Medica Performance -Based	Medica Choice Care Quality	Preferred One Updated	UCare P4P program Updated	DHS Reporting requirements	QCare	MN Community Measurement	2008 CMS PQRI Updated
33. Ear Care – Acute Otitis Externa*	x											x
34. Ear Care – Otitis Media with Effusion*												x
35. Elder Health Evaluation									x			
36. Electronic Clinical Data Reporting*			x									
37. End Stage Renal Disease*												x
38. Eye Care – Primary Open Angle Glaucoma*												x
39. Eye Care – Age related Macular Degeneration*												x
40. Eye Care – Diabetic Retinopathy*												x
41. Functional status*				x								
42. Gastroesophageal Reflux Disease (GERD)*												x
43. Generic drug use*	x		x	x								
44. Generic Prescribing Provider Decision Support			x									
45. Health information technology (HIT)*	x		x								To be added in 2008	x
46. Hepatitis C*												X
47. Hypertension							x				x	
48. Immunization rate – adolescents*										x		
49. Immunization rate – Children*							x	x	x	x	x	
50. Immunizations-Adults*												x
51. Innovations in Health Care*				x								
52. Language and race documentation			x									
53. Low back pain–Pain management			x									
54. Medication Reconciliation*												x
55. Meniscectomy Arthroscopy			x									
56. MNCM Direct Data Submission Participation			x									
57. Osteoarthritis*												x
58. Osteoporosis*												x
59. Pain assessment*												x
60. Palliative Care Program*			x									
61. Pathology												x
62. Patient satisfaction/ experience*				x							x	
63. PeriOperative Care*												x



Measure	BCBS MN 2008 Recognizing	Bridges to Excellence 2007-2008	HealthPartners Partners in Progress	HealthPartners Partners in Excellence	Medica Performance -Based	Medica Choice Care Quality	Preferred One Updated	UCare P4P program Updated	DHS Reporting requirements	QCare	MN Community Measurement	2008 CMS PQRI Updated
64. Pharyngitis*							x				x	x
65. Pneumonia*				Included in Preventive Services Composite Measure						x		
66. Rheumatoid Arthritis*												x
67. Safety Composite Assessment			x									
68. Screening - Blood lead level*			x			x		x	x		x	
69. Screening - Breast cancer*				x			x	x	x	x	x	x
70. Screening - Cervical cancer*				x			x	x	x	x	x	
71. Screening – Chlamydia*	x			Included in Preventive Services Composite Measure	x	x	x	x	x	x	x	
72. Screening – Clinical Depression*												x
73. Screening – Cognitive Impairment*												x
74. Screening - Colorectal cancer*				Included in Preventive Services Composite Measure			x	x			x	x
75. Screening - Composite cancer	x			Included in Preventive Services Composite Measure			x				x	
76. Screening – Future Falls Risk*												x
77. Screening – Preventative Services Composite - Adults				x								

Measure	BCBS MN 2008 Recognizing	Bridges to Excellence 2007-2008	HealthPartners Partners in Progress	HealthPartners Partners in Excellence	Medica Performance -Based	Medica Choice Care Quality	Preferred One Updated	UCare P4P program Updated	DHS Reporting requirements	QCare	MN Community Measurement	2008 CMS PQRI Updated
78. Screening – Preventative Services Composite - Pediatrics				x								
79. Screening - Standardized alcohol abuse screen*	x			Included in Preventive Services Composite Measure								
80. Screening and Intervention Process for ED			x									
81. Spinal Surgery	x											
82. Stroke and Stroke Rehab*												x
83. Syncope*												x
84. Tobacco – Identification*			x									x
85. Tobacco - Assisting smokers to quit*	x											x
86. Total hip or total knee replacement	x										In development 2008	
87. Total joint antibiotic prophylaxis*	x											
88. Upper respiratory Infection - Appropriate treatment for children*							x				x	x
89. Urinary Incontinence*												x
90. Well child visits – Infants								x		x	Retired 2007	
91. Well child visits – 3-6 years old								x	x		Retired 2007	

Source: Minnesota Medical Association)

### Minnesota Community Measurement Measures (NCQA HEDIS / ICSI)

Minnesota Community Measurement measures are identified in the table above and in the detailed measure descriptions found on the MMA detailed measures tables.

The following lists MNMCM measures:

#### MNMCM measures

- Asthma

- Cancer Screening:
  - Breast
  - Cervical
  - Colorectal
  - Cancer Screening Combined(Ages 50–80)
- Childhood Immunization
- Chlamydia Screening
- Controlling High Blood Pressure
- Optimal Diabetes Care\*
- Pharyngitis
- Upper Respiratory Infection
- Optimal Vascular Care
- Optimal Coronary Artery Disease
- (CAD) Care\*\*
- Depression\*\*
- Patient Experience\*\*\*
- Health Information Technology\*\*

Measures recently retired:

- Childhood Immunization (*Combo 2*)
- Depression Medication Management
- High Blood Pressure – (*old target*)
- Optimal Diabetes Care (*old targets*)
- Well Child Visits

Measures being considered for the future:

- CAD re-named Optimal Vascular Care\*\*
- Asthma all-or-none measure\*\*
- Specialty measure
- Cost of care / resource use
- Other care settings

MNCM is also implementing new depression measures that include outcome as well as process measures:

1. Percentage of Adult Population Diagnosed with Major Depression or Dysthymia:  
 Adults (ages 18 and older) with a diagnosis of depression. Depression is common, with a lifetime risk for major depressive disorder of 7%-12% for men and 20%-25% for women (*U.S. Department of Health and Human Services Public Health Service, 1993*). The depression codes for these measures will be:

- 296.2 - Major Depressive disorder, single episode
- 296.3 – Major depressive disorder, recurrent episode
- 300.4 – Dysthymic Disorder

# adult patients with depression (296.2x, 296.3x and 300.4)

total # adult patients

Typical population statistics in primary care:

Major Depression (296.2 and 296.3) – 5-9% prevalence women, 2-3% prevalence for Dysthymia (300.4) = 3% point prevalence in population

2. Percentage of Adult Population with Depression NOS Diagnosis: Adults (ages 18 and older) with a **diagnosis of 311 – Depressive disorder**, not elsewhere classified. PHQ-9 Response and Remission rates have not been validated for this diagnosis, and thus this information will be collected only for determining the proportion of patients given this diagnosis. *These patients will not be included in the subsequent measures.*

# of adult patients with diagnosis of depression not elsewhere classified (311)

# total adult patients

Typical population statistics in primary care:

Depression Disorder NOS, 311 = 11% of population

3. Percentage of Adult Population who had PHQ-9 at Baseline: Percent of patients with a diagnosis of depression (296.2, 296.3 or 300.4) with a completed PHQ-9 at first (index) contact (+ 30 days) where depression was coded in the measurement period. Contact is defined as an office visit, telephone call, or e-visit with any practitioner.

# adult pts with depression (296.2x, 296.3x and 300.4) who had a PHQ-9 administered

# adult patients with depression (296.2x, 296.3x and 300.4)

4. Number of Adult Patients with depression and a PHQ-9 > 9 at Index Contact: The number of patients with a PHQ-9 of > 9 at the index contact. Index contact is defined as the starting visit associated with a contact date in which the patient has a PHQ-9 score > 9 and ICD9 codes identifying the patient as having major depression or dysthymia.) This number serves as the denominator for measuring patient improvement at six and twelve months

Depression Outcome Measures:

The following table is a list of measures that can be calculated based on the direct data submission that occurs.

- For the 2009 BTE rewards program, the only measure that will be used is the six-month remission rate defined as a six-month PHQ-9 score of < 5.
- Response is defined as a 50% or more reduction of PHQ-9 score
- Remission is defined as a PHQ-9 score of less than 5
- PHQ-9 scores will be included if they are plus or minus 30 days of the point of measurement. For example a patient's index contact date is 2/15/2008. The six month date from this time would be 8/15/2008, but the patients contact date for

PHQ-9 is 8/27/2008; this PHQ-9 score and date would be accepted because it is within the 60 day grace period.

Measure	Calculation
PHQ-9 follow-up assessment at six months	$\frac{\# \text{ adult pts with depression \& PHQ-9 } > 9 \text{ who have 6 month PHQ-9 (+/- 30 days)}}{\# \text{ adult pts with depression with index contact PHQ-9 } > 9}$
PHQ-9 with a 50 % or more decrease in score (response) at six months	$\frac{\# \text{ adult pts with } \geq 50\% \text{ decrease in PHQ-9 score at 6 months}}{\# \text{ adult pts with depression with index contact PHQ-9 } > 9}$
PHQ-9 score < 5 (remission) at six months Note: BTE Measure	$\frac{\# \text{ adult pts with a PHQ-9 score } < 5 \text{ at 6 months}}{\# \text{ adult pts with depression with index contact PHQ-9 } > 9}$
PHQ-9 follow-up assessment at twelve months	$\frac{\# \text{ adult pts with depression \& PHQ-9 } > 9 \text{ who have 12 month PHQ-9 (+/- 30 days)}}{\# \text{ adult pts with depression with index contact PHQ-9 } > 9}$
PHQ-9 with a 50 % or more decrease in score (response) at twelve months	$\frac{\# \text{ adult pts with } \geq 50\% \text{ decrease in PHQ-9 score at 12 months}}{\# \text{ adult pts with depression with index contact PHQ-9 } > 9}$
PHQ-9 score < 5 (remission) at twelve months	$\frac{\# \text{ adult pts with a PHQ-9 score } < 5 \text{ at 12 months}}{\# \text{ adult pts with depression with index contact PHQ-9 } > 9}$

(Source: Minnesota Community Measurement)

### Professional Liability Prevention Measures

Another potential source of quality measures is the liability prevention activities of physician malpractice insurers. This approach has also been considered by the Colorado Guideline Collaborative using measures from their physician-owned malpractice consortium in Colorado. In Minnesota, this opportunity is being forwarded by Midwest Medical Insurance Company (MMIC). As a physician-owned medical professional liability insurance company, they have the acceptance of the physicians and work in their interest to help practices and institutions avoid mistakes that can lead to lawsuits.

MMIC has developed criteria by which they assess the level of malpractice risk clinics and hospitals face due to their internal systems, policies and procedures, and have developed recommended systems to help minimize those risks. The criteria that help liability insurers determine whether a healthcare facility is at low or high risk for malpractice claims can also be used to help assess the quality and patient safety levels of the facility.

Attached in Appendix B is list of risk management criteria and possible measures of those criteria and is intended only as a sample of what could be developed. Also is a risk management self-assessment that includes many other criteria that could be considered.

## **Section VI – Prioritizing Measures for Minnesota – Overview**

With such a large menu of new measures from which to select, the process of evaluating measures must be guided by the usual concerns with measure validity, reliability, "action-ability", attribution fairness, adequate risk adjustment, and population health impact. In addition, for Minnesota, the NQMC measures and measures of interest from other sources will need to be reviewed with consideration of the state's objectives and unique measurement capabilities.

National priorities and related national evaluations of measures often apply to Minnesota, but some national conclusions will be less applicable. We will need to recognize where national priorities and conventional wisdom regarding a measure's feasibility and acceptability are based on applying nationally focused, least common denominator assumptions about data limitations or the feasibility of achieving a community-wide coordinated action related to performance measurement.

The NQMC includes extensive information about the evidence-base and current uses of measures. Some of that information will require a Minnesota-specific review. An example would be for measures that have typically not been considered for use at the individual provider level because of small sample size for a specific provider through one payer. Were such a caveat raised nationally, Minnesota, with MNMCM and its legislated statewide objective, may have fewer constraints. Another constraint on national priorities, including Medicare, is the limitations of claims/administrative data. The CMS PQRI reporting includes intermediate outcomes reported on a HCFA 1500 claims using G codes. This is a workable "work-around" to overcome the limitations of claims data; however, Minnesota may have greater opportunity to implement outcome measurement because physician practices can report clinical data directly. Similarly, the MHA clinical data project sponsored by AHRQ is another example of advanced data availability potential. It is important to note that the clinical data not only allows for more extensive outcomes measurement, but also allows for improved risk adjusters as well.

## Appendices:

### APPENDIX A – Examples Search and Comparisons from NQMC

#### 1) Measures of Diabetic Nephropathies

[Diseases \(MeSH Category\)](#) - [List all 1184 measures](#)

[Endocrine System Diseases](#) - [List all 122 measures](#)

[Diabetes Mellitus](#) - [List all 103 measures](#)

[Diabetes Complications](#) - [List all 26 measures](#)

[Diabetic Nephropathies](#) - [List all 8 measures](#)

Display results 1 to 8 of 8

[Adult diabetes: percentage of patients who received any test for microalbuminuria.](#) National Diabetes Quality Improvement Alliance 2003 May. NQMC:000606

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[Adult diabetes: percentage of patients with at least one test for microalbumin during the measurement year; or who had evidence of medical attention for existing nephropathy \(diagnosis of nephropathy or documentation of microalbuminuria or albuminuria\).](#) National Diabetes Quality Improvement Alliance 2003 May. NQMC:000600

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[Adult diabetes: percentage of patients with no urinalysis or urinalysis with negative or trace urine protein, who received a test for microalbumin.](#) National Diabetes Quality Improvement Alliance 2003 May. NQMC:000607

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[Comprehensive diabetes care: percentage of members 18 through 75 years of age with diabetes mellitus \(type 1 and type 2\) who had a nephropathy screening test or evidence of nephropathy.](#) National Committee for Quality Assurance 2007 Jul. NQMC:002775

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[Diabetes mellitus: hospital admission rate for long-term complications.](#) Agency for Healthcare Research and Quality 2007 Mar. NQMC:003105

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[Diabetes mellitus: percent of eligible patients with a diagnosis of diabetes mellitus having a nephropathy screening test during the past year or documented evidence of nephropathy.](#) Veterans Health

Administration 2007 Oct. NQMC:003814

[Diabetes mellitus: the percentage of patients with diabetes who have a record of estimated glomerular filtration rate \(eGFR\) or serum creatinine testing in the previous 15 months.](#)

British Medical Association

National Health System (NHS) Confederation

2006 Feb. NQMC:001920

[Diabetes mellitus: the percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months \(exception reporting for patients with proteinuria\).](#)

British Medical Association

National Health System (NHS) Confederation

2006 Feb. NQMC:001919

## 2) Comparison of diabetes measures based on age of population (ages 13-18 years old)

### Measure Comparison

<b>Title</b>	<a href="#">Diabetes mellitus: the percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5 mmol/l or less.</a>	<a href="#">Diabetes mellitus: the percentage of patients with diabetes in whom the last HbA1c is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.</a>	<a href="#">Diabetes mellitus: the percentage of patients with diabetes in whom the last HbA1c is 10 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.</a>	<a href="#">Diabetes mellitus: the percentage of patients with diabetes in whom the last blood pressure is 145/85 or less.</a>	<a href="#">Diabetes mellitus: the percentage of patients with diabetes whose notes record body mass index (BMI) in the previous 15 months.</a>
<b>Measure Collection</b>	<a href="#">Quality and Outcomes Framework Indicators</a>	<a href="#">Quality and Outcomes Framework Indicators</a>	<a href="#">Quality and Outcomes Framework Indicators</a>	<a href="#">Quality and Outcomes Framework Indicators</a>	<a href="#">Quality and Outcomes Framework Indicators</a>
<b>Submitter</b>	British Medical	British Medical	British Medical	British Medical	British Medical



	Association National Health System (NHS) Confederation	Association National Health System (NHS) Confederation	Association National Health System (NHS) Confederation	Association National Health System (NHS) Confederation	Association National Health System (NHS) Confederation
<b>Developer</b>	British Medical Association National Health System (NHS) Confederation	British Medical Association National Health System (NHS) Confederation	British Medical Association National Health System (NHS) Confederation	British Medical Association National Health System (NHS) Confederation	British Medical Association National Health System (NHS) Confederation
<b>Funding Source(s)</b>	The expert panel who developed the indicators are entirely funded by a grant from the English Department of Health.	The expert panel who developed the indicators are entirely funded by a grant from the English Department of Health.	The expert panel who developed the indicators are entirely funded by a grant from the English Department of Health.	The expert panel who developed the indicators are entirely funded by a grant from the English Department of Health.	The expert panel who developed the indicators are entirely funded by a grant from the English Department of Health.
<b>Composition of the Group that Developed the Measure</b>	The main indicator development group is based in the National Primary Care Research and Development Centre in the University of Manchester. They are: Professor Helen Lester NPCRDC, MB BCH MD, Dr. Stephen Campbell, NPCRDC, PhD, Dr. Umesh Chauhan, NPCRDC, MB BS, PhD.	The main indicator development group is based in the National Primary Care Research and Development Centre in the University of Manchester. They are: Professor Helen Lester NPCRDC, MB BCH MD, Dr. Stephen Campbell, NPCRDC, PhD, Dr. Umesh Chauhan, NPCRDC, MB BS, PhD. Others involved in the development of individual	The main indicator development group is based in the National Primary Care Research and Development Centre in the University of Manchester. They are: Professor Helen Lester NPCRDC, MB BCH MD, Dr. Stephen Campbell, NPCRDC, PhD, Dr. Umesh Chauhan, NPCRDC, MB BS, PhD. Others involved in the development of individual	The main indicator development group is based in the National Primary Care Research and Development Centre in the University of Manchester. They are: Professor Helen Lester NPCRDC, MB BCH MD, Dr. Stephen Campbell, NPCRDC, PhD, Dr. Umesh Chauhan, NPCRDC, MB BS, PhD.	The main indicator development group is based in the National Primary Care Research and Development Centre in the University of Manchester. They are: Professor Helen Lester NPCRDC, MB BCH MD, Dr. Stephen Campbell, NPCRDC, PhD, Dr. Umesh Chauhan, NPCRDC, MB BS, PhD.

	Others involved in the development of individual indicators are: Professor Richard Hobbs, Dr. Richard McManus, Professor Jonathan Mant, Dr. Graham Martin, Professor Richard Baker, Dr. Keri Thomas, Professor Tony Kendrick, Professor Brendan Delaney, Professor Simon De Lusignan, Dr. Jonathan Graffy, Dr. Henry Smithson, Professor Sue Wilson, Professor Claire Goodman, Dr. Terry O'Neill, Dr. Philippa Matthews, Dr. Simon Griffin, Professor Eileen Kaner.	indicators are: Professor Richard Hobbs, Dr. Richard McManus, Professor Jonathan Mant, Dr. Graham Martin, Professor Richard Baker, Dr. Keri Thomas, Professor Tony Kendrick, Professor Brendan Delaney, Professor Simon De Lusignan, Dr. Jonathan Graffy, Dr. Henry Smithson, Professor Sue Wilson, Professor Claire Goodman, Dr. Terry O'Neill, Dr. Philippa Matthews, Dr. Simon Griffin, Professor Eileen Kaner.	indicators are: Professor Richard Hobbs, Dr. Richard McManus, Professor Jonathan Mant, Dr. Graham Martin, Professor Richard Baker, Dr. Keri Thomas, Professor Tony Kendrick, Professor Brendan Delaney, Professor Simon De Lusignan, Dr. Jonathan Graffy, Dr. Henry Smithson, Professor Sue Wilson, Professor Claire Goodman, Dr. Terry O'Neill, Dr. Philippa Matthews, Dr. Simon Griffin, Professor Eileen Kaner.	Others involved in the development of individual indicators are: Professor Richard Hobbs, Dr. Richard McManus, Professor Jonathan Mant, Dr. Graham Martin, Professor Richard Baker, Dr. Keri Thomas, Professor Tony Kendrick, Professor Brendan Delaney, Professor Simon De Lusignan, Dr. Jonathan Graffy, Dr. Henry Smithson, Professor Sue Wilson, Professor Claire Goodman, Dr. Terry O'Neill, Dr. Philippa Matthews, Dr. Simon Griffin, Professor Eileen Kaner.	Others involved in the development of individual indicators are: Professor Richard Hobbs, Dr. Richard McManus, Professor Jonathan Mant, Dr. Graham Martin, Professor Richard Baker, Dr. Keri Thomas, Professor Tony Kendrick, Professor Brendan Delaney, Professor Simon De Lusignan, Dr. Jonathan Graffy, Dr. Henry Smithson, Professor Sue Wilson, Professor Claire Goodman, Dr. Terry O'Neill, Dr. Philippa Matthews, Dr. Simon Griffin, Professor Eileen Kaner.
<b>Financial Disclosures/Other Potential Conflicts of Interest</b>	None for the main indicator development group.	None for the main indicator development group.	None for the main indicator development group.	None for the main indicator development group.	None for the main indicator development group.

<b>Release Date</b>	2004 Apr	2004 Apr	2004 Apr	2004 Apr	2004 Apr
<b>Revision Date</b>	2006 Feb	2006 Feb	2006 Feb	2006 Feb	2006 Feb
<b>Description</b>	This measure is used to assess the percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5 mmol/l or less.	This measure is used to assess the percentage of patients with diabetes in whom the last HbA1c is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.	This measure is used to assess the percentage of patients with diabetes in whom the last HbA1c is 10 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.	This measure is used to assess the percentage of patients with diabetes in whom the last blood pressure is 145/85 or less.	This measure is used to assess the percentage of patients with diabetes whose notes record body mass index (BMI) in the previous 15 months.
<b>Rationale</b>	Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over one million people in the United Kingdom (UK) having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetic patients, particularly patients with	Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over one million people in the United Kingdom (UK) having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetic patients, particularly patients with Type 2 diabetes is undertaken by the general practitioner and members of the	Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over one million people in the United Kingdom (UK) having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetic patients, particularly patients with Type 2 diabetes is undertaken by the general practitioner and members of the	Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over one million people in the United Kingdom (UK) having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetic patients, particularly patients with	Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over one million people in the United Kingdom (UK) having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetic patients, particularly patients with

	<p>Type 2 diabetes is undertaken by the general practitioner and members of the primary care team. This measure is one of sixteen <a href="#">Diabetes Mellitus</a> measures.</p> <p>The <a href="#">Diabetes Mellitus</a> indicators are based on widely recognised approaches to the care of diabetes. Detailed guidelines for health professionals are published by Diabetes UK and by SIGN - the Scottish Intercollegiate Guidelines Network. The SIGN website contains detailed evidence tables, and links to published articles. The English National Service Framework for Diabetes also</p>	<p>primary care team. This measure is one of sixteen <a href="#">Diabetes Mellitus</a> measures.</p> <p>The <a href="#">Diabetes Mellitus</a> indicators are based on widely recognised approaches to the care of diabetes. Detailed guidelines for health professionals are published by Diabetes UK and by SIGN - the Scottish Intercollegiate Guidelines Network. The SIGN website contains detailed evidence tables, and links to published articles. The English National Service Framework (NSF) for Diabetes also includes details of the evidence behind a range of recommendations. The National Institute for Health and Clinical Excellence (NICE) has also published guidance on a number of aspects of diabetic control. The indicators for diabetes are</p>	<p>primary care team. This measure is one of sixteen <a href="#">Diabetes Mellitus</a> measures.</p> <p>The <a href="#">Diabetes Mellitus</a> indicators are based on widely recognised approaches to the care of diabetes. Detailed guidelines for health professionals are published by Diabetes UK and by SIGN - the Scottish Intercollegiate Guidelines Network. The SIGN website contains detailed evidence tables, and links to published articles. The English National Service Framework for Diabetes also</p>	<p>Type 2 diabetes is undertaken by the general practitioner and members of the primary care team. This measure is one of sixteen <a href="#">Diabetes Mellitus</a> measures.</p> <p>The <a href="#">Diabetes Mellitus</a> indicators are based on widely recognised approaches to the care of diabetes. Detailed guidelines for health professionals are published by Diabetes UK and by SIGN - the Scottish Intercollegiate Guidelines Network. The SIGN website contains detailed evidence tables, and links to published articles. The English National Service Framework for Diabetes also</p>	<p>Type 2 diabetes is undertaken by the general practitioner and members of the primary care team. This measure is one of sixteen <a href="#">Diabetes Mellitus</a> measures.</p> <p>The <a href="#">Diabetes Mellitus</a> indicators are based on widely recognised approaches to the care of diabetes. Detailed guidelines for health professionals are published by Diabetes UK and by SIGN - the Scottish Intercollegiate Guidelines Network. The SIGN website contains detailed evidence tables, and links to published articles. The English National Service Framework for Diabetes also</p>
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	<p>includes details of the evidence behind a range of recommendations. The National Institute for Health and Clinical Excellence (NICE) has also published guidance on a number of aspects of diabetic control.</p> <p>The indicators for diabetes are generally those which would be expected to be done, or checked in an annual review. There is no requirement on the general practitioner (GP) practice to carry out all these items (e.g., retinal screening), but it is the practice's responsibility to ensure that they have been done.</p> <p>This set of indicators relates to both Type 1 and Type 2</p>	<p>generally those which would be expected to be done, or checked in an annual review. There is no requirement on the general practitioner (GP) practice to carry out all these items (e.g., retinal screening), but it is the practice's responsibility to ensure that they have been done.</p> <p>This set of indicators relates to both Type 1 and Type 2 diabetes. Although the care of patients with Type 1 diabetes may be shared with specialists, the general practitioner would still be expected to ensure that appropriate annual checks had been carried out.</p> <p>For each individual a target HbA1c should be set between 6.5 percent and 7.5 percent based on the risk of macrovascular and microvascular complications (NICE, Management of</p>	<p>generally those which would be expected to be done, or checked in an annual review. There is no requirement on the general practitioner (GP) practice to carry out all these items (e.g., retinal screening), but it is the practice's responsibility to ensure that they have been done.</p> <p>This set of indicators relates to both Type 1 and Type 2 diabetes. Although the care of patients with Type 1 diabetes may be shared with specialists, the general practitioner would still be expected to ensure that appropriate annual checks had been carried out.</p> <p>Reaching optimal levels of control (HbA1c 7.5 or less) in diabetic patients is difficult. For this reason a second outcome indicator has been introduced to encourage working with patients with high</p>	<p>includes details of the evidence behind a range of recommendations. The National Institute for Health and Clinical Excellence (NICE) has also published guidance on a number of aspects of diabetic control.</p> <p>The indicators for diabetes are generally those which would be expected to be done, or checked in an annual review. There is no requirement on the general practitioner (GP) practice to carry out all these items (e.g., retinal screening), but it is the practice's responsibility to ensure that they have been done.</p> <p>This set of indicators relates to both Type 1 and Type 2</p>	<p>includes details of the evidence behind a range of recommendations. The National Institute for Health and Clinical Excellence (NICE) has also published guidance on a number of aspects of diabetic control.</p> <p>The indicators for diabetes are generally those which would be expected to be done, or checked in an annual review. There is no requirement on the general practitioner (GP) practice to carry out all these items (e.g., retinal screening), but it is the practice's responsibility to ensure that they have been done.</p> <p>This set of indicators relates to both Type 1 and Type 2</p>
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	<p>diabetes. Although the care of patients with Type 1 diabetes may be shared with specialists, the general practitioner would still be expected to ensure that appropriate annual checks had been carried out.</p> <p>If total cholesterol is greater than 5.0 mmol/l, statin therapy to reduce cholesterol should be initiated and titrated as necessary to reduce total cholesterol to less than 5 mmol/l. There is ongoing debate concerning the intervention levels of serum cholesterol in diabetic patients who do not apparently have cardiovascular disease. Further National Guidance is</p>	<p>Blood Glucose, 2002).</p> <p>For the purposes of the Quality Outcomes Framework (QOF) 7.5 (or equivalent) has been selected as an optimal level of control for the purposes of audit and reporting. Where fructosamine is used, for example in patients with haemoglobinopathies, local standards may need to be developed for this indicator. The fructosamine value is derived as follows:</p> $\text{Fructosamine} = (\text{HbA1c} - 1.61) / 0.017 = 346 \mu\text{mol/l}$ <p>The evidence for the targets for HbA1c are based on the Diabetes Control and Complications Trial (DCCT) study in Type 1 diabetes, which found few microvascular complications in those with HbA1c below 7.5 (N Engl J Med, 1993). The</p>	<p>HbA1c to bring the level to 10 or less. Where fructosamine is used, for example in patients with haemoglobinopathies, local standards may need to be developed for this indicator. The fructosamine value is derived as follows:</p> $\text{Fructosamine} = (\text{HbA1c} - 1.61) / 0.017 = 346 \mu\text{mol/l}$ <p>It is recognised that there may be variations in test availability and in normal ranges in different parts of the UK. If this is the case, the primary care organisation (PCO) may stipulate a different but equivalent range for this indicator.</p>	<p>diabetes. Although the care of patients with Type 1 diabetes may be shared with specialists, the general practitioner would still be expected to ensure that appropriate annual checks had been carried out.</p> <p>Blood pressure lowering in people with diabetes reduces the risk of macrovascular and microvascular disease. Hypertension in people with diabetes should be treated aggressively with lifestyle modification and drug therapy (SIGN 55, 2001).</p> <p>The most commonly identified target level for blood pressure in patients with diabetes is 140/80. This is the level that</p>	<p>diabetes. Although the care of patients with Type 1 diabetes may be shared with specialists, the general practitioner would still be expected to ensure that appropriate annual checks had been carried out.</p> <p>Weight control in overweight subjects with diabetes is associated with improved glycaemic control. There is little evidence to dictate the frequency of recording but it is general clinical practice that body mass index (BMI) is assessed at least annually.</p>
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	<p>awaited.</p> <p>The age when a statin should be initiated is unclear. It is pragmatically suggested that all diabetic patients over the age of 40 with a cholesterol of greater than 5 mmol/l should be treated with a statin. Below the age of 40 a decision needs to be reached between the doctor and the patient and may involve assessment of other risk factors and the actual age of the patient.</p>	<p>authors of the NICE guidelines for Type 2 diabetes (2002) use this to argue for HbA1c levels below 7.5 in Type 2 diabetics.</p> <p>Although there is less direct evidence to support a specific threshold for risk of macrovascular disease in Type 2 diabetes, the 7.5 percent threshold seems reasonable as a quality indicator for the purposes of QOF, and should play a role in shifting the overall distribution of blood glucose downwards in those with diabetes.</p> <p>It is recognised that there may be variations in test availability and in normal ranges in different parts of the UK. If this is the case, the primary care organisation (PCO) may stipulate a different but equivalent range for this indicator, but it should be noted that the</p>		<p>health professionals should aim for. A slightly higher level (145/85) is used as the audit standard in common with other indicators.</p>	
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		National Diabetes Support Team has advised that all laboratories should now report DCCT aligned results. This issue is discussed in the English NSF under Standards: Supplementary information: Clinical care of adults with diabetes: Monitoring blood glucose control (NSF, 2002).			
<b>Primary Measure Domain</b>	<p><b>Outcome</b></p> <p>The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the <a href="#">Measure Validity</a> page.</p>	<p><b>Outcome</b></p> <p>The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the <a href="#">Measure Validity</a> page.</p>	<p><b>Outcome</b></p> <p>The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the <a href="#">Measure Validity</a> page.</p>	<p><b>Outcome</b></p> <p>The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the <a href="#">Measure Validity</a> page.</p>	<p><b>Process</b></p> <p>The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the <a href="#">Measure Validity</a> page.</p>
<b>Evidence Supporting the Criterion of Quality</b>	<ul style="list-style-type: none"> <li>• A formal consensus procedure involving experts in relevant clinical, methodological, and organizational sciences</li> <li>• One or more</li> </ul>	<ul style="list-style-type: none"> <li>• A clinical practice guideline or other peer-reviewed synthesis of the clinical evidence</li> <li>• A formal consensus procedure involving experts in relevant</li> </ul>	<ul style="list-style-type: none"> <li>• A formal consensus procedure involving experts in relevant clinical, methodological, and organizational sciences</li> </ul>	<ul style="list-style-type: none"> <li>• A clinical practice guideline or other peer-reviewed synthesis of the clinical evidence</li> <li>• A formal consensus procedure involving</li> </ul>	<ul style="list-style-type: none"> <li>• A clinical practice guideline or other peer-reviewed synthesis of the clinical evidence</li> <li>• A formal consensus procedure involving</li> </ul>



	research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal	clinical, methodological, and organizational sciences <ul style="list-style-type: none"> <li>One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal</li> </ul>		experts in relevant clinical, methodological, and organizational sciences	experts in relevant clinical, methodological, and organizational sciences
<b>Evidence Supporting the Value of Monitoring the Aspect of Population Health</b>	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
<b>Evidence Supporting the Value of Monitoring Use of Service</b>	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
<b>Extent of Measure Testing</b>	Unspecified	Unspecified	Unspecified	Unspecified	Unspecified
<b>Denominator Inclusions/Exclusions</b>	<p><b>Inclusions</b> Patients with diabetes</p> <p><b>Exclusions</b> Exclude those patients age 16 years and under and patients with gestational diabetes. See "Description of Case Finding" field for</p>	<p><b>Inclusions</b> Patients with diabetes</p> <p><b>Exclusions</b> Exclude those patients age 16 years and under and patients with gestational diabetes. See "Description of Case Finding" field for exception</p>	<p><b>Inclusions</b> Patients with diabetes</p> <p><b>Exclusions</b> Exclude those patients age 16 years and under and patients with gestational diabetes. See "Description of Case Finding" field for exception</p>	<p><b>Inclusions</b> Patients with diabetes</p> <p><b>Exclusions</b> Exclude those patients age 16 years and under and patients with gestational diabetes. See "Description of Case Finding" field for</p>	<p><b>Inclusions</b> Patients with diabetes</p> <p><b>Exclusions</b> Exclude those patients age 16 years and under and patients with gestational diabetes. See "Description of Case Finding" field for</p>

	exception reporting.	reporting.	reporting.	exception reporting.	exception reporting.
<b>Relationship of Denominator to Numerator</b>	All cases in the denominator are equally eligible to appear in the numerator	All cases in the denominator are equally eligible to appear in the numerator	All cases in the denominator are equally eligible to appear in the numerator	All cases in the denominator are equally eligible to appear in the numerator	All cases in the denominator are equally eligible to appear in the numerator
<b>Numerator Inclusions/Exclusions</b>	<p><b>Inclusions</b> Number of patients from the denominator whose last measured total cholesterol within the previous 15 months is 5 mmol/l or less</p> <p><b>Exclusions</b> Unspecified</p>	<p><b>Inclusions</b> Number of patients from the denominator in whom the last HbA1c is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months</p> <p><b>Exclusions</b> Unspecified</p>	<p><b>Inclusions</b> Number of patients from the denominator in whom the last HbA1c is 10 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months</p> <p><b>Exclusions</b> Unspecified</p>	<p><b>Inclusions</b> Number of patients from the denominator in whom the last blood pressure is 145/85 or less*</p> <p>*Note: The pressure must have been measured in the previous 15 months.</p> <p><b>Exclusions</b> Unspecified</p>	<p><b>Inclusions</b> Number of patients from the denominator whose notes record body mass index (BMI) in the previous 15 months</p> <p><b>Exclusions</b> Unspecified</p>
<b>Measure Results Under Control of Health Care Professionals, Organizations and/or Policymakers</b>	The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.	The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.	The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.	The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.	The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.
<b>Data Source</b>	Laboratory data Medical record	Laboratory data Medical record	Laboratory data Medical record	Medical record	Medical record

	Registry data	Registry data	Registry data	Registry data	Registry data
<b>Level of Determination of Quality</b>	Not Individual Case	Not Individual Case	Not Individual Case	Not Individual Case	Individual Case
<b>Allowance for Patient Factors</b>	Unspecified	Unspecified	Unspecified	Unspecified	Unspecified
<b>Scoring</b>	Rate	Rate	Rate	Rate	Rate
<b>Interpretation of Score</b>	Better quality is associated with a higher score	Better quality is associated with a higher score	Better quality is associated with a higher score	Better quality is associated with a higher score	Better quality is associated with a higher score
<b>Current Use</b>	Internal quality improvement National reporting Pay-for-performance	Internal quality improvement National reporting Pay-for-performance	Internal quality improvement National reporting Pay-for-performance	Internal quality improvement National reporting Pay-for-performance	Internal quality improvement National reporting Pay-for-performance
<b>Care Setting</b>	Physician Group Practices/Clinics	Physician Group Practices/Clinics	Physician Group Practices/Clinics	Physician Group Practices/Clinics	Physician Group Practices/Clinics
<b>Professionals Responsible for Health Care</b>	Physicians	Physicians	Physicians	Physicians	Physicians
<b>Lowest Level of Health Care Delivery Addressed</b>	Group Clinical Practices	Group Clinical Practices	Group Clinical Practices	Group Clinical Practices	Group Clinical Practices

### 3) List of Cardiologist Measures

#### Measures

Cardiac rehabilitation: percentage of patients in the healthcare system's cardiac rehabilitation program(s) who meet the specified performance measure criteria for tobacco use. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003776




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Cardiac rehabilitation: percentage of patients in the healthcare system's cardiac rehabilitation program(s) who meet the specified performance measure criteria for assessment of exercise capacity. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003783




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Cardiac rehabilitation: percentage of patients in the healthcare system's cardiac rehabilitation program(s) who meet the specified performance measure criteria for blood pressure control. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003777




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Cardiac rehabilitation: percentage of patients in the healthcare system's cardiac rehabilitation program(s) who meet the specified performance measure criteria for lipid control. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003778




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Cardiac rehabilitation: percentage of patients in the healthcare system's cardiac rehabilitation program(s) who meet the specified performance measure criteria for physical activity habits. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003779



Cardiac rehabilitation: percentage of patients in the healthcare system's cardiac rehabilitation program(s) who meet the specified performance measure criteria for assessment of weight management. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003780

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Cardiac rehabilitation: percentage of patients in the healthcare system's cardiac rehabilitation program(s) who meet the specified performance measure criteria for diabetes mellitus or impaired fasting glucose. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003781

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Acute coronary syndrome (ACS): percent of patients hospitalized with ACS found to be high or moderate-high risk patients with cardiology involvement in care within 24 hours of acute arrival or if AMI as inpatient, within 24 hours of initial ECG or first positive troponin whichever is earlier. Veterans Health Administration 2007 Oct NQMC:002485

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Coronary heart disease: the percentage of patients with newly diagnosed angina (diagnosed after 1 April 2003) who are referred for exercise testing and/or specialist assessment. British Medical Association National Health System (NHS) Confederation 2006 Feb NQMC:001878

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Cardiac rehabilitation: percentage of patients in the healthcare system's cardiac rehabilitation program(s) who meet the specified performance measure criteria for adherence to preventive medications. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003784

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Cardiac rehabilitation: percentage of cardiac rehabilitation program(s) in the healthcare system that meet the specified performance measure criteria for communication with healthcare providers. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003785

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Cardiac rehabilitation: percentage of cardiac rehabilitation programs in the health system that meet this

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specified performance measure criteria for monitoring response to therapy and documenting program effectiveness. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003786

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Cardiac rehabilitation: percentage of eligible inpatients with a qualifying event/diagnosis who have been referred to an outpatient cardiac rehabilitation program prior to hospital discharge or have a documented medical or patient-centered reason why such a referral was not made. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003771



Cardiac rehabilitation: percentage of cardiac rehabilitation programs in the healthcare system that meet specified structure-based performance measure criteria. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003773



Cardiac rehabilitation: percentage of cardiac rehabilitation programs in the healthcare system that meet the specified performance measure criteria for assessment of risk for adverse cardiovascular events. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003774



Cardiac rehabilitation: percentage of patients in the healthcare system's cardiac rehabilitation program(s) who meet the specified performance measure criteria for depression. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003782



Cardiac rehabilitation: percentage of patients in an outpatient clinical practice who have had a qualifying event/diagnosis during the previous 12 months, who have been referred to an outpatient cardiac rehabilitation program. American Association of Cardiovascular and Pulmonary Rehabilitation/American College of Cardiology/American Heart Association 2007 Sep NQMC:003772



### Appendix B – Example Measures from the MMIC

<b>Criteria</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Follow up system for abnormal results	None	Policy developed	Staff verbalize understanding	Documentation demonstrates compliance
External diagnostic studies have been read by physician prior to filing in record as evidenced by chart review	<75%	76-85%	86-95%	>95%
Non-compliance with treatment plan addressed	No evidence	Process in place for identification and addressing	Evidence in record that compliance or non-compliance identified	Evidence in record that non-compliance addressed
Medication flow sheet present in chart that includes lab work associated with medication	<50%	50-75%	76-90%	>90%
Methodology in place for tracking trends for chronic disease management	<50%	50-75%	76-90%	>90%
Nationally recognized guidelines are used for patients with diabetes	No		Yes	
System is in place for managing and documenting after hours calls	No	Log system	Notes to primary physician	Primary physician signs off and call is documented in record
Process is in place for evaluating clinical practice of physicians	No			Yes
Patient education system is in place and utilized as demonstrated in medical record	No	<60%	61-90%	>90%
Visit summary given to patient at end of visit including all follow-up instructions	No	<60%	61-90%	>90%