NATIONAL QUALITY FORUM

Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

NQF #: 0028
De.2. **Measure Title:** Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
Co.1.1. **Measure Steward:** AMA-convened Physician Consortium for Performance Improvement
De.3. **Brief Description of Measure:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user
1b.1. **Developer Rationale:** This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products, thereby increasing the proportion of smokers who successfully quit which in turn results in a decreased risk for heart disease, stroke, and lung disease.

S.4. **Numerator Statement:** Patients who were screened for tobacco use* at least once within 24 months AND who received tobacco cessation counseling intervention** if identified as a tobacco user

*Includes use of any type of tobacco
** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy
S.7. **Denominator Statement:** All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
S.10. **Denominator Exclusions:** Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)

De.1. **Measure Type:** Process
S.23. **Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Medical Records
S.26. **Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team

IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Nov 02, 2012

IF this measure is included in a composite, NQF Composite#/title:
2597:Substance Use Screening and Intervention Composite

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

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

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

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

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form
0028_Evidence_MSF5.0_Data.doc

1b. Performance Gap

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

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

1b.1. Briefly explain the rationale for this measure *(e.g., the benefits or improvements in quality envisioned by use of this measure)*
This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products, thereby increasing the proportion of smokers who successfully quit which in turn results in a decreased risk for heart disease, stroke, and lung disease.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*
A 2006 study analyzed data from the National Ambulatory Medical Care Survey (NAMCS) and found suboptimal rates of "asking" about tobacco use, providing "assistance" with tobacco cessation, and prescribing pharmacotherapy for cessation. Overall, 32% of patient charts did not include information about tobacco use, 81% of smokers did not receive assistance and less than 2% received a prescription for pharmacotherapy.(1) The Agency for Healthcare Research and Quality's 2010 National Healthcare Quality Report analyzed 2007 data from the Medical Expenditure Panel Survey and found that 66.2% of current adult smokers overall who had a checkup in the last 12 months were advised to quit smoking.(2) A more recent CDC analysis of 2010 National Health Interview Surveys (NHIS) data found that less than half of smokers (48.3%) who saw a health professional in the past year reported receiving advice to quit. (3)

An earlier version of this measure was included in CMS' Physician Quality Reporting System (PQRS) program from 2008-2010 which included separate measures for each component – inquiry regarding tobacco use and advising smokers to quit. In 2011 and 2012, the current version of this measure which combines both components into 1 measure is utilized. Mean performance rates from 2008 and 2009, the most recent data that has been made publicly available, are as follows (4):
Inquiry Regarding Tobacco Use
2008: 64.84% among 8,302 eligible professionals submitting
2009: 76.56% among 20, 819 eligible professionals submitting
Advising Smokers to Quit
2008: 47.62% among 4,432 eligible professionals submitting
2009: 56.29% among 10,597 eligible professionals submitting

It is important to note that PQRS is currently a voluntary reporting program, with about 20% of eligible professionals participating in 2009, and performance rates may not be nationally representative.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.
1. Ferketich AK, Khan Y, Wewers ME. Are physicians asking about tobacco use and assisting with cessation? Results from the 2001-2004 national ambulatory medical care survey (NAMCS). Prev Med. 2006 Dec;43(6):472-6.
2. Agency for Healthcare Research and Quality. 2010 National Healthcare Quality Report. Rockville, MD. Available at: http://www.ahrq.gov/qual/nhqr10/nhqr10.pdf.
3. Centers for Disease Control and Prevention (CDC). Quitting Smoking Among Adults --- United States, 2001—2010. MMWR Morb Mortal Wkly Rep. 2011 Nov 11; 60(44);1513-1519.
4. CMS. 2009 Reporting Experience Including Trends (2007 – 2010): Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program
4/4/2011. Available at: https://www.cms.gov/PQRS. Accessed 3/21/2012.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*
Variations in smoking prevalence persist, particularly by race/ethnicity, education, income, and region. Specifically, among racial/ethnic populations, non-Hispanic American Indians/Alaska Natives had the highest prevalence (31.4%), followed by non-

Hispanic whites (21.0%) and non-Hispanic blacks (20.6%). Smoking prevalence generally decreased with increasing education and was higher among adults living below the poverty level (28.9%) than among those at or above the poverty level (18.3%). (1)

A recent CDC analysis of 2010 National Health Interview Surveys (NHIS) data found that among those who had visited a health-care provider, women (51.7%) and persons aged >=65 years (57.1%) were more likely to have received cessation advice. Hispanic smokers were less likely (34.7%) to have received advice to quit than other racial/ethnic populations. Those without a health plan (35.3%) were least likely to have received cessation advice, whereas Medicare enrollees (59.0.%) were the most likely to receive advice.(2)

This is in slight contrast to the data reported by AHRQ's 2010 National Healthcare Disparities report which found no statistically significant differences by race and ethnicity in the percentage of current adult smokers who received advice to quit smoking. From 2002 to 2007, female current adult smokers continued to be more likely than males to receive advice to quit smoking. Additionally, in 2007, near-poor current adult smokers were significantly less likely than high-income current adult smokers to receive advice to quit smoking (58.8% compared with 67.8%). (3)

1b.5. **If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.**

1. Centers for Disease Control and Prevention (CDC). Vital signs: current cigarette smoking among adults aged =18 years--United States, 2005-2010. MMWR Morb Mortal Wkly Rep. 2011 Sep 9;60(35):1207-12.
2. Centers for Disease Control and Prevention (CDC). Quitting Smoking Among Adults --- United States, 2001—2010. MMWR Morb Mortal Wkly Rep. 2011 Nov 11; 60(44);1513-1519.
3. Agency for Healthcare Research and Quality. 2010 National Healthcare Disparities Report. Rockville, MD. Available at: http://www.ahrq.gov/qual/nhdr10/nhdr10.pdf.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. **Demonstrated high priority aspect of healthcare**

Affects large numbers, A leading cause of morbidity/mortality

1c.2. **If Other:**

1c.3. **Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.**

Tobacco use remains the single largest preventable cause of death and disease in the United States.(1) The health consequences of tobacco use include heart disease, multiple types of cancer, pulmonary disease, adverse reproductive effects, and the exacerbation of chronic health conditions (2). Each year, approximately 443,000 persons in the United States die from smoking-related illnesses. In addition, smoking has been estimated to cost the United States $96 billion in direct medical expenses and $97 billion in lost productivity each year (3). In 2010, an estimated 19.3% (45.3 million) of U.S. adults were current cigarette smokers; of these, 78.2% smoked every day, and 21.8% smoked some days.(1) Prevalence was higher among men (21.5%) than women (17.3%). Adults aged 25--44 years (22.0%) and 45--64 years (21.1%) had the highest prevalences among age groups.(1) Current cigarette smoking prevalence among all adults aged >=18 years has decreased 42.4% since 1965, but declines in current smoking prevalence have slowed during the past 5 years.(4) During 2005--2010, the overall proportion of U.S. adults who were current smokers declined from 20.9% to 19.3%.(1) An recent analysis of National Health and Nutrition Examination Survey (NHANES) data found that approximately 76% of current smokers have at least one outpatient office visit each year, representing a significant opportunity to screen for tobacco use and deliver effective cessation interventions.(5)

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

1. Centers for Disease Control and Prevention (CDC). Vital signs: current cigarette smoking among adults aged =18 years--United States, 2005-2010. MMWR Morb Mortal Wkly Rep. 2011 Sep 9;60(35):1207-12.
Citing:
2. US Department of Health and Human Services. How tobacco smoke causes disease: the biology and behavioral basis for smoking-

attributable disease: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 2010. Available at http://www.cdc.gov/tobacco/data_statistics/sgr/2010/index.htm. Accessed August 4, 2011.
3. CDC. Smoking-attributable mortality, years of potential life lost, and productivity losses---United States, 2000--2004. MMWR 2008;57:1226--8.
4. Centers for Disease Control and Prevention (CDC). Quitting Smoking Among Adults --- United States, 2001—2010. MMWR Morb Mortal Wkly Rep. 2011 Nov 11; 60(44);1513-1519.
5. Kahende JW, Adhikari B, Maurice E, Rock V, Malarcher A. Disparities in Health Care Utilization by Smoking Status – NHANES 1999-2004. Int. J. Environ. Res. Public Health. 2009, 6(3), 1095-1106.

1c.5. **If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful.** *(Describe how and from whom their input was obtained.)*

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. ***Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.***

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. **Subject/Topic Area** *(check all the areas that apply):*
Prevention, Prevention : Tobacco Use

De.6. **Cross Cutting Areas** *(check all the areas that apply):*
Prevention

S.1. **Measure-specific Web Page** *(Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)*
Additional measure details at: CMS eCQM library webpage http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html. Value set details at VSAC webpage: https://vsac.nlm.nih.gov/

S.2a. **If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)
This is an eMeasure **Attachment:** EP_CMS138v4_NQF0028_PREV_Tobacco.zip

S.2b. **Data Dictionary, Code Table, or Value Sets** *(and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)*
Attachment **Attachment:** NQF_0028_CMS_138v4_Value_Set_Details.xlsx

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

S.4. **Numerator Statement** *(Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)*
IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.
Patients who were screened for tobacco use* at least once within 24 months AND who received tobacco cessation counseling intervention** if identified as a tobacco user

*Includes use of any type of tobacco

** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy

S.5. **Time Period for Data** *(What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)*
Once within 24 months (measurement period or year prior)

S.6. **Numerator Details** *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*
IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.
Definitions: Tobacco Use – Includes any type of tobacco
Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy

For Claims/Registry:
CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user
OR
CPT II 1036F: Current tobacco non-user
OR
CPT Category I code-Smoking and tobacco-use cessation counseling
*The following codes are applicable if the patient screened positive for smoking/tobacco use and counseling was provided..
99406: Smoking/tobacco counseling 3-10 minutes
99407: Smoking/tobacco counseling greater than 10 minutes

For EHR:
HQMF eMeasure developed and is included in this submission.

S.7. **Denominator Statement** *(Brief, narrative description of the target population being measured)*
All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

S.8. **Target Population Category** *(Check all the populations for which the measure is specified and tested if any):*
Populations at Risk, Populations at Risk : Individuals with multiple chronic conditions, Senior Care

S.9. **Denominator Details** *(All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses , code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*
For Claims/Registry:

CPT E/M Service Code:
Two visits during the measurement period
99201, 99202, 99203, 99204
99205, 99212, 99213, 99214, 99215
97003, 97004
92004, 92012, 92014
90791, 90792
90832, 90834, 90837
90845
96150, 96151, 96152

At least one visit during the measurement period
92521, 92522, 92523, 92524, 92540, 92557, 92625
99385, 99386, 99387
99395, 99396, 99397
99401, 99402, 99403, 99404

99411, 99412
99420, 99429
G0438, G0439

For EHR:
HQMF eMeasure developed and is included in this submission

S.10. **Denominator Exclusions** *(Brief narrative description of exclusions from the target population)*
Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)

S.11. **Denominator Exclusion Details** *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*
Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure 0028, exceptions may include medical reasons (eg, limited life expectancy, other medical reason) for not screening for tobacco use.Where examples of exceptions are included in the measure language, value sets for these examples are developed and included in the eMeasure. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

For Claims/Registry:
CPT II 4004F-1P: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons)

For EHR:
HQMF eMeasure developed and is included in this submission.

S.12. **Stratification Details/Variables** *(All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)*
Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

S.13. **Risk Adjustment Type** (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)
No risk adjustment or risk stratification
If other:

S.14. **Identify the statistical risk model method and variables** *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)*
No risk adjustment or risk stratification

S.15. **Detailed risk model specifications** *(must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)*
Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

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

S.16. **Type of score:**
Rate/proportion
If other:

S.17. **Interpretation of Score** *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*
Better quality = Higher score

S.18. **Calculation Algorithm/Measure Logic** *(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)*
To calculate performance rates:
1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.
3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.
4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, limited life expectancy)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

S.19. **Calculation Algorithm/Measure Logic Diagram URL or Attachment** *(You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)*

S.20. **Sampling** *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*
IF a PRO-PM, identify whether (and how) proxy responses are allowed.
Not applicable. The measure does not require sampling or a survey.

S.21. **Survey/Patient-reported data** *(If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)*
IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.22. **Missing data** (specify how missing data are handled, e.g., imputation, delete case.)
Required for Composites and PRO-PMs.

S.23. **Data Source** *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*
If other, please describe in S.24.
Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Medical Records

S.24. **Data Source or Collection Instrument** *(Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)*
IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.
Not applicable.

S.25. **Data Source or Collection Instrument** *(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)*

S.26. **Level of Analysis** *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)*
Clinician : Group/Practice, Clinician : Individual, Clinician : Team

S.27. **Care Setting** *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*
Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient, Other
If other: Speech and Hearing Evaluation, Occupational Therapy Evaluation, Ophthalmological Visits

S.28. **COMPOSITE Performance Measure** - Additional Specifications *(Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)*

2a. Reliability – See attached Measure Testing Submission Form
2b. Validity – See attached Measure Testing Submission Form
0028_MeasureTesting_MSF5.0_Data.doc

3. Feasibility

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

3a. Byproduct of Care Processes

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

3a.1. **Data Elements Generated as Byproduct of Care Processes.**
generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition
If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. **To what extent are the specified data elements available electronically in defined fields?** *(i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)*
ALL data elements are in defined fields in electronic health records (EHRs)

3b.2. **If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.**

3b.3. **If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.**
Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements

and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. **Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.**
IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.
This measure was found to be reliable and feasible for implementation.

3c.2. **Describe any fees, licensing, or other requirements to use any aspect of the measure as specified** *(e.g., value/code set, risk model, programming code, algorithm)*.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. **Current and Planned Use**

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Planned	Current Use (for current use provide URL)
Public Reporting Professional Certification or Recognition Program Quality Improvement (Internal to the specific organization)	

4a.1. **For each CURRENT use, checked above, provide:**

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

4a.2. **If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons?** (*e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?*)

4a.3. **If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement.** (*Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.*)

4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. **Progress on Improvement. (Not required for initial endorsement unless available.)**
Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- **Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)**
- **Geographic area and number and percentage of accountable entities and patients included**

4b.2. **If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.**

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. **Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.**
We are not aware of any unintended consequences related to this measurement.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.
Yes

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

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

5a. Harmonization

The measure specifications are harmonized with related measures;
OR
The differences in specifications are justified

5a.1. **If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):**
Are the measure specifications completely harmonized?
No

5a.2. **If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.**
Our measure focuses on routine tobacco screening for all adults and tobacco cessation interventions for those who use tobacco

products. Measure 0026 includes infants, children and adolescents and therefore appropriately also assesses for exposure to tobacco smoke. Also, the cessation intervention required by our measure includes brief counseling and/or pharmacotherapy in light of the strong support for these interventions in the guidelines and the feasibility of implementing these practices as part of routine care. Measure 0027 is a patient survey measure and includes one additional component of the cessation intervention beyond our measure (ie, discussion of methods or strategies other than medication).

5b. Competing Measures

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

5b.1. **If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):**
Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)
No competing measures.

Appendix

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

Contact Information

Co.1 **Measure Steward (Intellectual Property Owner):** AMA-convened Physician Consortium for Performance Improvement
Co.2 **Point of Contact:** Samantha, Tierney, Samantha.Tierney@ama-assn.org, 312-464-5524-
Co.3 **Measure Developer if different from Measure Steward:** American Medical Association - convened Physician Consortium for Performance Improvement (AMA-convened PCPI)
Co.4 **Point of Contact:** Samantha, Tierney, samantha.tierney@ama-assn.org, 312-464-5524-

Additional Information

Ad.1 **Workgroup/Expert Panel involved in measure development**
Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.
Gail M. Amundson, MD, FACP (internal medicine/geriatrics)
Joel V. Brill MD, AGAF, FASGE, FACG (gastroenterology)
Steven B. Clauser, PhD
Will Evans, DC, Phd, CHES (chiropractic)
Ellen Giarelli, EdD, RN, CRNP (nurse practitioner)
Amy L. Halverson, MD, FACS (colon & rectal surgery)
Alex Hathaway, MD, MPH, FACPM
Charles M. Helms, MD, Phd (infectious disease)
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Daniel Kivlahan, PhD (psychology)
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PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study must be equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 **Year the measure was first released:** 2001

Ad.3 **Month and Year of most recent revision:** 09, 2008

Ad.4 **What is your frequency for review/update of this measure?** Coding/Specifications updates occur annually. See additional information below.

Ad.5 **When is the next scheduled review/update for this measure?** 2012

Ad.7 **Disclaimers:** See copyright statement above.
Ad.8 **Additional Information/Comments:** The PCPI has a formal measurement review process that stipulates regular (usually on a three-year cycle, when feasible) review of the measures. The process can also be activated if there is a major change in scientific evidence, results from testing or other issues are noted that materially affect the integrity of the measure.