

NQF-Endorsed Measures for Care Coordination: Phase 3, 2014

TECHNICAL REPORT

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Executive Summary

Care Coordination is a multidimensional concept that encompasses—among many other facets of healthcare organization and delivery—the effective communication between patients and their families, caregivers, and healthcare providers; safe care transitions; a longitudinal view of care that considers the past, while monitoring delivery of care in the present and anticipating the needs of the future; and the facilitation of linkages between communities and the healthcare system to address medical, social, educational, and other support needs, in alignment with patient goals. Considered a fundamental component to the success of healthcare systems and improved patient outcomes, establishing effective communication within and across the continuum of care will help to improve the quality and affordability of our system. According to the Institute of Medicine (IOM), it is estimated that there is a potential opportunity of \$240 billion in savings resulting from care coordination initiatives such as patient education and the development of new provider payment models.

Currently, NQF's portfolio of care coordination measures include measures for emergency department transfers, plan of care, e-prescribing, timely transitions, medication management, transition records, and medical home. Although many of these are among NQF's newer measures, dating back to 2007, several are currently being used in public and/or private accountability and quality improvement programs.

Recognizing the need to establish a meaningful foundation for future development of a set of practices with demonstrated impact on patient outcomes, NQF endorsed a definition and measurement framework for care coordination, establishing five domains essential to measurement in 2010. In July 2011, NQF launched a multi-phased Care Coordination project focused on health care coordination across episodes of care and care transitions. The first phase of the project sought to address the lack of cross-cutting measures in the NQF measure portfolio by developing a path forward for meaningful measures of care coordination leveraging health information technology. This work was strengthened by the development of a commissioned paper examining electronic capabilities to support care coordination measurement as well as the findings of an [environmental scan](#). The Steering Committee used these findings to discuss the pathway forward and the goals for future measures. These goals were reflected in the second phase call for measures; however NQF did not receive any new measures for review despite extensive targeted outreach to solicit new measures that address cross-cutting components of care coordination.¹

In Phase 3 of this project, the Standing Committee evaluated 12 measures: one new measure and 11 measures undergoing maintenance review against NQF's standard evaluation criteria. Eleven of the

measures were recommended for endorsement by the Committee, and one was not recommended (#0487: EHR with EDI prescribing used in encounters where a prescribing event occurred). Following review of the measures, the Committee recommended that a suite of seven measures regarding Emergency Transfer Communication be combined into one measure. The developer combined the measures and a total of five measures were recommended by the Standing Committee:

- 0291: Emergency Transfer Communication
- 0495: Median Time from ED Arrival to ED Departure for Admitted ED Patients
- 0496: Median Time from ED Arrival to ED Departure for Discharged ED Patients
- 0497: Admit Decision Time to ED Departure Time for Admitted Patients
- 2456: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Brief summaries of the measures currently under review are included in the body of this report; detailed summaries of the Committee's discussion and ratings of the criteria are included in Appendix A. Five existing measures in the portfolio were retired and were not reviewed; details are included in Appendix A.

Introduction

Care Coordination is a multidimensional concept that encompasses—among many other facets of healthcare organization and delivery—the effective communication between patients and their families, caregivers, and healthcare providers; safe care transitions; a longitudinal view of care that considers the past, while monitoring delivery of care in the present and anticipating the needs of the future; and the facilitation of linkages between communities and the healthcare system to address medical, social, educational, and other support needs, in alignment with patient goals.

Because poorly coordinated care regularly leads to unnecessary suffering for patients, as well as avoidable readmissions and emergency department visits, increased medical errors, and higher costs, coordination of care is increasingly recognized as critical for improvement of patient outcomes and the success of healthcare systems. For example, individuals with chronic conditions and multiple co-morbidities—and their families and caregivers—often find it difficult to navigate our complex and fragmented healthcare system. As this ever-growing group transitions from one care setting to another, poor outcomes resulting from incomplete or inaccurate transfer of information, poor communication, and a lack of follow-up care become more likely. Yet the sharing of information across settings and between providers through electronic health records (EHRs) could reduce the unnecessary and costly duplication of patient services,¹ while the number of serious medication events could be reduced through patient education and the reconciliation of medication lists.² The Agency for Healthcare Research and Quality estimates that adverse medication events cause more than 770,000 injuries and deaths each year, more than half of which affect those over age 65.³ The cost of treating patients who are harmed by these events is estimated to be as high as \$5 billion annually.⁴ Furthermore, the Institute of Medicine has found that care coordination initiatives such as patient education and the development of new provider payment models could result in an estimated \$240 billion in savings.⁵

Due to the multi-disciplinary nature of effective care coordination, NQF's efforts in this area have been diverse. NQF began to address the complex issue of care coordination measurement in 2006. At that time, sufficiently developed measures of care coordination could not be identified for endorsement. However, NQF did endorse a definition and a framework for care coordination measurement.⁶ The definition characterized care coordination as a "function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time" and the framework identified five domains essential to the future measurement of care coordination, as follows:

- Healthcare Home
- Proactive Plan of Care and Follow-Up;
- Communication;
- Information Systems; and
- Transitions or Handoffs.

The standardized definition and endorsed framework established a strong foundation for continued work in this area.

In 2010, NQF published the *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination Consensus Report*.⁷ The measures submitted to this project were predominately condition-specific process or survey-based measures, with very few crossing providers or settings. Through this project, 10 performance measures were endorsed; however, these measures addressed only two of the domains within the Care Coordination Framework (Transitions and Proactive Plan of Care). Recognizing the need to establish a meaningful foundation for future development of a set of practices with demonstrated impact on patient outcomes, NQF additionally endorsed 25 Preferred Practices through this project. These practices were considered suitable for widespread implementation and could be applied and generalized across multiple care settings.

In its role as the convener of the National Priorities Partnership (NPP), NQF supports the priorities and goals identified by the Department of Health and Human Services' (HHS) National Quality Strategy.⁸ NPP have long supported care coordination as a national priority. In 2010, NPP convened a Care Coordination workgroup that identified actions to achieve reductions in 30-day readmissions. Workgroup members identified barriers to achieving this goal and discussed opportunities to leverage health information technology and build system capacity. In preparation for this workshop, NQF commissioned a background paper: *Aligning Our Efforts to Achieve Care Coordination*. This paper offered an overview of the national state of care coordination activities and recommended high-level drivers of change.

Meanwhile, the HIT team at NQF initiated a project to assess the readiness of electronic data and health IT systems to support quality measurement of care planning during transitions of care, as well as provide recommendations for advancing such infrastructure. The expert panel convened for this project completed a review of industry initiatives related to the plan of care use in care coordination, workflow and data components related to the plan of care, and identification of the characteristics of the plan of care. This work informed an [environmental scan](#) to develop a baseline understanding of the use of HIT to support transitions of care and quality measurement. NQF worked with Brigham and Women's

Hospital to conduct the [environmental scan](#), and the results demonstrate the opportunity to improve data capture and exchange to support patient-centered, longitudinal plans of care. The TEP made recommendations to advance the capture of essential care plan data elements at the point of care, promote the adoption of interoperability standards, and enhance the use of care plan data in decision support. These recommendations could greatly advance quality improvement and measurement activities of care coordination. In 2012, NQF's Measure Applications Partnership (MAP) identified an initial group of measure families, sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the National Quality Strategy (NQS) priorities and high-impact conditions. MAP's Families of Measures report released October 1, 2012 includes a Care Coordination Measure Family with 62 available measures and a number of measure gap areas. The family includes measures addressing avoidable admissions and readmissions, system infrastructure support, care transitions, communication, care planning, and patient surveys related to care coordination. The MAP's Recommendations for Measures released January 28, 2014 included previously identified priority gap areas for care coordination in the areas of communication, system and infrastructure support and avoidable admissions and readmissions.

Building on previous work, in 2013 HHS engaged NQF to pursue a Care Coordination gaps prioritization project. The prioritization work is concurrent with this project and is focused on assessing the status of measure gaps more broadly, and is intended to further advance the aims and priorities of the National Quality Strategy by identifying priorities for performance measurement; scanning for potential measures and measure concepts to address these priorities; and developing multi-stakeholder recommendations for future measure development and endorsement. This work is discussed in greater detail in the section of this report entitled "[Improving NQF's Care Coordination Portfolio](#)."

In this phase of the Care Coordination project, the measures submitted for review focused on emergency department transfers, medication reconciliation and timely transitions. While these are key areas within care coordination measurement, these measures do not fully address the domains within the Care Coordination Framework.

Emergency Department Transfers

In 2005, 85 percent of emergency department (ED) visits ended in discharges. Developing protocols or standards of practice to arrange the transition to outpatient care is an integral part of care coordination. Poor communication during transitions leads to increased rates in hospital readmissions, medical errors, and poor health outcomes. It is extremely difficult to reach the emergency department or hospital once a transfer is complete and use of care coordination strategies at the time of transfer can help ensure that the patient information is transmitted fully and in a timely fashion.⁹

Medication Reconciliation

Medication reconciliation refers to the process of avoiding inadvertent inconsistencies during transitions in care by reviewing the patient's complete medication regimen at the time of admission, transfer, and discharge and comparing it with the regimen being considered for the new care setting.

Such unintended inconsistencies—the omission of needed medications, unnecessary duplication of existing therapies or incorrect dosages in medication regimens— may occur at any point of transition in

care. Studies have shown that unintended medication discrepancies occur for nearly one-third of patients at admission; a similar proportion at the time of transfer from one site of care within a hospital, and in 14 percent of patients at hospital discharge, which highlights this as a significant care coordination issue.¹⁰

Timely Transitions

Poorly managed and untimely transitions can diminish health and increase health care costs. Researchers have estimated that inadequate care coordination, including inadequate management of care transitions, was responsible for \$25 to \$45 billion in wasteful spending in 2011 for avoidable complications and unnecessary hospital readmissions. Without effective, timely communication between physicians, both the quality of care and the patient experience can suffer. Establishing efficient and effective approaches transitions is essential to not only improving patient and family experiences but helping to minimize readmission rates.¹¹

National Quality Strategy

The National Quality Strategy (NQS) serves as the overarching framework for guiding and aligning public and private efforts across all levels (local, State, and national) to improve the quality of health care in the U.S.¹² The NQS establishes the "triple aim" of better care, affordable care, and healthy people/communities, focusing on six priorities to achieve those aims: *Safety, Person and Family Centered Care, Communication and Care Coordination, Effective Prevention and Treatment of Illness, Best Practices for Healthy Living, and Affordable Care*.¹³ Improvement efforts for emergency transfers, medication reconciliation and transition time are consistent with the NQS triple aim and align with the of NQS priority of Communication and Care Coordination. Coordination of care is a priority because it helps to ensure that the patient and family needs and preferences regarding health services and information sharing across people, functions, and sites are met over time. Effective care coordination maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, and high-quality patient experiences and improved healthcare outcomes.

Impact of Measurement

Care coordination is a vital aspect of health and healthcare services. When care is poorly coordinated—with inaccurate transmission of information, inadequate communication, and inappropriate follow-up care—patients who see multiple physicians and care providers can face medication errors, hospital readmissions, and avoidable emergency department visits. The effects of poorly coordinated care are particularly evident for people with chronic conditions, such as diabetes and hypertension, and those at high risk for multiple illnesses who often are expected to navigate a complex healthcare system. These standards will provide the structure, process, and outcome measures required to assess progress toward care coordination goals and to evaluate access, continuity, communication, and tracking of patients across providers and settings. Given the high-risk nature of transitions in care, this work will build on ongoing efforts among the medical and surgical specialty societies to establish principles for effective patient hand-offs among clinicians and providers. As this ever-growing group attempts to navigate our complex healthcare system and transition from one care setting to another, they often are unprepared or unable to manage their care. Incomplete or inaccurate transfer of information, poor

communication, and a lack of appropriate follow-up care can lead to confusion and poor outcomes, including medication errors and often preventable hospital readmissions and ED visits.⁷

Care Coordination Measure Evaluation: Refining the Evaluation Process

A change to the Consensus Development Process (CDP): transitioning to Standing Steering Committees; has been incorporated into the ongoing maintenance activities for the Care Coordination portfolio. This change is described below.

Standing Steering Committee

In an effort to remain responsive to its stakeholders' needs, NQF is constantly working to improve the CDP. Volunteer, multi-stakeholder steering committees are the central component to the endorsement process, and the success of the CDP projects is due in large part to the participation of its Steering Committee members. In the past, NQF initiated the Steering Committee nominations process and seated new project-specific committees only when funding for a particular project had been secured. Seating new committees with each project not only lengthened the project timeline, but also resulted in a loss of process continuity and consistency because committee membership changed—often quite substantially—over time.

To address these issues in the CDP, NQF is transitioning to the use of Standing Steering Committees for various topic areas. These Standing Committees will oversee the various measure portfolios; this oversight function will include evaluating both newly-submitted and previously-endorsed measures against NQF's measure evaluation criteria, identifying gaps in the measurement portfolio, providing feedback on how the portfolio should evolve, and serving on any ad hoc or expedited projects in their designated topic areas.

The Care Coordination Standing Committee currently includes 24 members (see Appendix D). Each member has been randomly appointed to serve an initial two- or three- year term, after which he/she may serve a subsequent three-year term if desired.

NQF Portfolio of performance measures for Care Coordination

Currently, NQF's portfolio of care coordination measures includes measures for emergency department transfers, plan of care, e-prescribing, timely transitions, medication management, transition records, and medical homes. This portfolio contains 20 measures: eight process measures, three outcome and resource use measures, eight structural measures, and one composite measure (see table below). Eleven of these existing measures were evaluated by the Care Coordination Committee in this phase.

NQF Care Coordination Portfolio of Measures

	Process	Outcome	Structural	Composite
Emergency Department Transfers	7	0	0	0
Plan of Care	1	0	0	0
E-prescribing	0	0	1	0
Timely Transitions	1	3	0	0
Medication Management	3	0	0	0
Transition Records	3	0	0	0
Medical Home	0	0	0	1
Total	15	3	1	1

The remaining nine measures are currently endorsed and not due for endorsement maintenance until August 2015, at which time may be reviewed for re-endorsement. Endorsement of measures by NQF is valued not only because the evaluation process itself is both rigorous and transparent, but also because evaluations are conducted by multi-stakeholder committees comprised of clinicians and other experts from hospitals and other healthcare providers, employers, health plans, public agencies, community coalitions, and patients—many of whom use measures on a daily basis to ensure better care. Moreover, NQF-endorsed measures undergo routine "maintenance" (i.e., re-evaluation) to ensure that they are still the best-available measures and reflect the current science. Importantly, legislative mandate requires that preference be given to NQF-endorsed measures for use in federal public reporting and performance-based payment programs. NQF measures also are used by a variety of stakeholders in the private sector, including hospitals, health plans, and communities.

Over time, and for various reasons, some previously-endorsed care coordination-related measures have been withdrawn from the full NQF portfolio (see Appendix A). In some cases, the measure steward may want to continue maintain the measure for endorsement (e.g., update specifications as new drugs/tests become available or as diagnosis/procedure codes evolve or go through NQF's measure maintenance process). In other cases, measures may lose endorsement upon maintenance review. Loss of endorsement can occur for many different reasons including—but not limited to—a change in evidence without an associated change in specifications, high performance on a measure signifying no further opportunity for improvement, and endorsement of a superior measure.

Use of measures in the portfolio

Many of the care coordination measures in the portfolio are among NQF's newer measures, several of which have been endorsed since 2008. Many are in use in at least one federal program. Also, several of the care coordination measures have been included in the Care Coordination Family of Measures by the NQF-convened Measure Applications Partnership (MAP). See Appendix C for details of federal program use for the measures in the portfolio that are currently under review.¹⁴

Improving NQF's Care Coordination Portfolio

Addressing Measure Gaps across Care Coordination Projects

Despite the set of measures endorsed in Phase 2 and an existing set of preferred practices, there remain significant gaps in the portfolio, and few meaningful, high impact measures of care coordination. For example, there is a lack of cross-cutting measures that span various types of providers and episodes of care. Such measures have the potential to be applied more broadly and be more useful for those with multiple chronic conditions.

A concurrent project at NQF –[Prioritizing Measure Gaps](#)– recommends the most fertile ground for meaningful measure development to HHS in five key areas, including care coordination. The care coordination topic area focuses on examining opportunities to measure care coordination in the context of a broad “health neighborhood,” and specifically explores coordination between safety-net providers of primary care and providers of community and social services that impact health. The work is intended to broaden the current scope of care coordination performance measurement and account for the influence of social determinants that affect health.

To ensure alignment between the measure prioritization project and the Care Coordination Standing Committee’s current measure evaluation project detailed in this report, NQF staff presented the measure domains and framework developed by the measure prioritization Committee to the standing Committee. The framework consists of three key measurement areas and a number of domains and sub-domains beneath each area. The overarching measurement areas are:

- Joint creation of a person-centered Plan of Care
 - *For example*, a comprehensive assessment including assessment of health literacy and activation level.
- Utilization of the Health Neighborhood to Execute the Plan of Care
 - *For example*, primary care providers identify appropriate community service and contact them based on the care recipient’s needs assessment.
- Achievement of Outcomes
 - *For example*, progress towards identified goals and experience of care measures.

The Standing Committee was then asked to discuss and recommend the most impactful and feasible areas for future measure development, understanding that a trade-off between measures’ impact and development feasibility naturally exists. Throughout the discussion, three overarching themes rose to the top. First, the Committee emphasized that although experiences are very important to measure, evidence-based approaches to achieving positive health outcomes are equally as important. The approach to care should be formed by both the care recipients’ priorities and evidence-based approaches to disease management.

The Committee also agreed that the ultimate goal should be to have measures that are truly impactful. So while a need exists to consider both the impact and the feasibility of measure development and implementation, impact should be weighted more heavily. The Committee finally stressed that potential measures’ application may differ based on the diverse environments in which they will be implemented (urban versus rural settings, for example). This reality implies the need for different types of new measures, including measures of both process and outcome.

The Measure Prioritization Committee met in-person on April 3-4, 2014 and heard from standing Committee co-chairs Don Casey and Gerri Lamb, who summarized the standing Committee's discussion. The final report, [*Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps in Care Coordination*](#) is available on the NQF [webpage](#).

Committee input on gaps in the portfolio

During their discussions the Committee identified numerous areas where additional measure development is needed, and persistent gaps across settings have been identified by the MAP¹⁵ and NQF staff (as part of a recent analysis of the full NQF portfolio), specifically:

- Measures of patient-caregiver engagement;
- Measures that evaluate “system-ness” rather than measures that address care within silos, and
- Outcome and composite measures, which are prioritized by both the Committee and the MAP over individual process and structural measures, but with the recognition that some of these latter measures are valuable.

Measures in the “pipeline”

NQF recently launched a *Measure Inventory Pipeline*—a virtual space for developers to share information on measure development activities. Developers can use the Pipeline to display data on current and planned measure development and to share successes and challenges. Information shared via the Pipeline is available in real time and can be revised at any time. NQF expects that developers will use the Pipeline as a tool to connect to, and collaborate with, their peers on measurement development ideas. Currently, no measures related to care coordination have been submitted to the Pipeline.

Care Coordination Measure Evaluation

In Phase 3 of the Care Coordination Measure Evaluation Review, the Care Coordination Standing Committee evaluated one new measure and 11 measures undergoing maintenance review against NQF's standard evaluation criteria.

The Committee met March 18th and 19th via webinar meeting and on a follow-up call on April 1st, to discuss these measures. To facilitate the evaluation, the Committee and candidate standards were divided into two workgroups for preliminary evaluation of the measures against the NQF criteria prior to consideration by the entire Standing Committee.

Care Coordination Phase 3 Measure Review Summary

	Maintenance	New	Total
Measures under consideration	11	1	12
Measures withdrawn from consideration	5	0	5
Measures consolidated (into a single measure)	7	0	7
Measures endorsed	4	1	5
Measures not endorsed	1	0	1
Reasons for not recommending	Importance		

Comments Received prior to Committee evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF has begun soliciting comments prior to the evaluation of the measures via an online tool located on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open February 6-20, 2014 for all of the measures under review; however no pre-evaluation comments were received.

Comments Received after Committee evaluation

The 30-day post-evaluation commenting period was open from April 29, 2014 through May 28, 2014. During this period, NQF received 75 comments from 6 member organizations. Overall themes were identified regarding use of the evidence exception, feasibility of the measures, construction of several recommended measure as composites, and gaps in the portfolio. Several of the comments received expressed recommendations and concerns regarding the specifications of the measures evaluated for endorsement. While there were several comments that were not supportive of the Committee's recommendations, most expressed their position on the measures, but did not offer additional information that would promote additional discussion of the measure. The Committee discussed these comments and took action on measure-specific comments as needed, during the Committee's post-comment call, which was held on June 12, 2014.

Overarching Issues

During the Committee's discussion of the measures, several overarching issues emerged that were factored into the Committee's ratings and recommendations for multiple measures and are not repeated in detail with each individual measure.

Insufficient Evidence Base

The Committee noted that NQF criteria have become more rigorous following the 2010 Task Force recommendations regarding evaluating evidence. In their review of a set of seven process measures related to patient transfers from emergency departments, the Committee concluded the evidence presented did not sufficiently support the claim that the measured processes improve health outcomes.

The Committee discussed the set of measures at length, noting that the evidence presented to support the measures was insufficient. The Committee acknowledged that the state of the evidence in this area is not ideal however, and noted that although the literature presented does not provide a direct link to patient outcomes, these measures display potential benefits to improve care coordination as they address a foundational and critical aspect of patient safety. The Committee noted the measures fill an important gap area regarding measures of emergency department transfers that are focused on transfers from rural hospitals to other facilities, and that the measures support the communication aspect of Care Coordination by ensuring that adequate communication occurs between transferring facilities (especially patients in rural hospitals who can be at higher risk) and accepting facilities. As a result, the Committee ultimately exercised an exception to the evidence criterion, agreeing that it is beneficial to hold providers accountable for performance in the absence of empirical evidence, and that the benefits of the measure outweigh potential harms. The Committee strongly recommended, however, that the seven measures be consolidated into one comprehensive measure, observing that the intent is to communicate a comprehensive set of patient information as part of ED transfers. The developer subsequently revised the measures into a single measure.

Unidirectional measurement

The Committee noted that several measures for review within this project established a “unidirectional” communication approach which does not ensure coordination has occurred. Although measurement around communication is essential, the Committee stressed the need for measures that are bi-directional in nature and that address other aspects of care related to communication. The Committee specifically emphasized the need for future measures that incorporate a “handshake” concept, meaning that the receipt of information needed to coordinate care as well as the transmittal of information should be included in measures. The Committee agreed however, that many of the measures for review address a gap area, and serve as a foundation for assessing where coordination measurement opportunities exist. Future opportunities lie in having these types of measures conceptually focused on the importance of coordinated efforts to relay information to and from providers across multiple settings.

Summary of Phase 3 Measure Evaluation

The following brief summaries of the measures and the evaluation highlight the major issues that were considered by the Committee. Details of the Committee’s discussion and ratings of the criteria are included in Appendix A.

Eleven previously NQF-endorsed measures and one newly submitted measure were reviewed. Seven of the existing measures were consolidated into a single measure, and as a result five measures were recommended for endorsement: four existing measures and one new measure.

0291: Emergency Transfer Communication (University of Minnesota Rural Health Research Center): Endorsed

Description: *Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that REQUIRED information was communicated to the receiving facility prior to departure (subsection 1) or within 30 minutes of transfer (subsection 2-7);*

Measure Type: Process; **Level of Analysis:** Facility; **Setting of Care:** Hospital/Acute Care Facility; **Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry

This measure is comprised of seven measures (measures #0291-0297) that have been NQF-endorsed since 2007. Public reporting in Minnesota has been delayed due to resource limitations; the Medicare Beneficiary Quality Improvement Project (MBQIP) has included the measures in [its phase 3 reporting plan](#). The Committee initially reviewed this measure as a set of seven measures regarding the communication of: administrative information, vital signs, medication information, patient information, physician Information, nursing Information, and procedures and tests in the transfer of patients from rural emergency departments to other facilities. The Committee noted that the evidence presented to support the focus of each separate measure is insufficient, but agreed to exercise the exception to the evidence criterion, noting the measure addresses a gap area; it is beneficial to hold providers accountable for performance of the measure in the absence of empirical evidence, and that the benefits of the measure outweigh potential harms. The Committee noted this measure addresses a high priority aspect of healthcare as transfer communication is a major contributing factor to adverse events in hospitals, accounting for 65 percent of sentinel events tracked by the Joint Commission, and that deficits exist in the transfer of patient information between hospitals and primary care physicians in the community, and between hospitals and long term facilities.

The Committee was concerned however, that each measure was intended to be reported together in order to communicate a comprehensive set of patient information as part of patient transfers. The Committee strongly recommended the measures be consolidated into a single measure noting that the resulting measure would have a higher impact. After discussion with the CSAC, the developer addressed the Committee's concerns and revised the measures into a single measure: #0291 Emergency Transfer Communication. The details of the revised measure are in Appendix G.

0495: Median Time from ED Arrival to ED Departure for Admitted ED Patients (Centers for Medicare and Medicaid Services): Endorsed

Description: Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department; **Measure Type:** Outcome; **Level of Analysis:** Facility; **Setting of Care:** Hospital/Acute Care Facility; **Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records

This measure has been NQF-endorsed since 2008, and is included in the CMS Hospital Inpatient Quality Reporting program and the Joint Commission accreditation program. The measure is intended to address reducing the time patients remain in the emergency department (ED), which can improve access to treatment and increase quality of care. The Committee agreed sufficient evidence is presented to support the measure. Reviewing performance on the measure since prior endorsement however, Committee members expressed concern that the five quarters of trend data provided over years 2012 and 2013 showed little to no improvement on the measure. The developer explained that this trend may continue as crowding in the ED continues to be a problem and may increase due to other factors (such

as the expansion of state Medicaid programs as part of the Affordable Care Act (ACA)). The Committee recommended the measure, agreeing the opportunity for improvement persists and that if performance is stagnating or declining, the measure is an important tool in assessing ED crowding and potentially monitoring the impacts of ACA implementation on ED crowding.

0496: Median Time from ED Arrival to ED Departure for Discharged ED Patients (Centers for Medicare and Medicaid Services): Endorsed

Description: Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department; **Measure Type:** Outcome; **Level of Analysis:** Facility; **Setting of Care:** Hospital/Acute Care Facility; **Data Source:** Administrative claims

This measure has been NQF-endorsed since 2008, and is included in the CMS Hospital Inpatient Quality Reporting program and the Joint Commission accreditation program. The measure is intended to address reducing the time patients remain in the emergency department (ED), which can improve access to treatment and increase quality of care. The Committee agreed sufficient evidence is presented to support the measure. Similar to measure 0495, in reviewing performance on the measure since prior endorsement, Committee members expressed concern that the 5 quarters of trend data provided over years 2012 and 2013 showed little to no improvement on the measure. The developer again explained that this trend may continue as crowding in the ED continues to be a problem and may increase due to other factors (such as the expansion of state Medicaid programs as part of the Affordable Care Act). Committee members also questioned whether psychiatric patients in the ED might be included in the measure. The developer explained that due to the difficulties of placing these patients they are not included in the measure for accountability purposes, but are included in a quality improvement measure. The Committee recommended the measure, agreeing the opportunity for improvement persists and that if performance is stagnating or declining, the measure is an important tool in assessing ED crowding and potentially monitoring the impacts of ACA implementation on ED crowding.

0497: Admit Decision Time to ED Departure Time for Admitted Patients (Centers for Medicare and Medicaid Services): Endorsed

Description: Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status; **Measure Type:** Process; **Level of Analysis:** Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual; **Setting of Care:** Hospital/Acute Care Facility; **Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry

This measure has been NQF-endorsed since 2008, and is included in the CMS Hospital Inpatient Quality Reporting program and the Joint Commission accreditation program. The measure is intended to address reducing the time patients remain in the emergency department (ED), which can improve access to treatment and increase quality of care. The Committee agreed that this measure speaks more directly to care coordination than 0495 and 0496 as it focuses on the time from the decision to admit, to actual patient discharge from the ED. The measure emphasizes the logistical aspects of care that occur after initial evaluation. The Committee noted that although the literature cited in support of the

measure does not appear to specifically address the narrow window of “decision to departure”, the Committee agreed that the evidence supports the importance of timely care and the poor outcomes associated with delays in care. The Committee recommended the measure, agreeing a gap in performance persists and that the measure addresses a high priority area.

2456: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient (Brigham and Women's Hospital): Endorsed

Description: *This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adult; Measure Type: Outcome; Level of Analysis: Facility; Setting of Care: Hospital/Acute Care Facility; Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Other, Paper Medical Records, Patient Reported Data/Survey, Electronic Clinical Data : Pharmacy*

This measure was newly submitted to NQF and, while not currently in use, is anticipated to be implemented within five years for use in accountability applications (a specific program was not identified). The Committee agreed the evidence presented to support the measure was sufficient: a systematic review was presented including 26 studies consistently demonstrating that medication reconciliation interventions result in a reduction in medication discrepancies, potential adverse drug events, adverse drug events, and a reduction in health care utilization. The studies were of fair quality, as graded by the United States Preventive Services Task Force (USPSTF). While the Committee agreed there is an opportunity for improvement, and the measure will have a high impact as a proxy outcome or short-term outcome of good care coordination around medication, Committee members noted there is not a strong connection between the measure and long-term error reduction and overall better patient outcomes. The Committee agreed however, that this measure more closely approximates aspirational measures of care coordination as it incorporates a check and balance component that goes beyond simply checking that a procedure was done. The Committee recommended that further study be done to determine the long-term benefits of medication reconciliation interventions and the results be presented in future. Committee members also raised concerns about the feasibility of the measure, and the potential need for a study pharmacist to implement to measure, but ultimately agreed to recommend the measure.

0487: EHR with EDI prescribing used in encounters where a prescribing event occurred. (City of New York Department of Health and Mental Hygiene): Not Endorsed

Description: *Of all patient encounters within the past month that used an electronic health record (EHR) with electronic data interchange (EDI) where a prescribing event occurred, how many used EDI for the prescribing event.; Measure Type: Structure; Level of Analysis: Clinician : Individual; Setting of Care: Ambulatory Care : Clinician Office/Clinic; Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy*

This measure has been NQF-endorsed since 2008 and is in use in the Primary Care Information Project, which is part of New York City Department of Health & Mental Hygiene. Reviewing the evidence presented to support the measure, Committee members expressed concerns that measuring the

number of electronic prescriptions will not lead to meaningful conclusions about or improvements in quality of care. The developer presented studies displaying a high prevalence of medication errors, however the Committee noted that the studies do not show a clear link between the measurement of the number of electronic prescriptions and health outcomes. As a result, the Committee agreed the evidence presented is insufficient to support the measure and that there is low confidence that the measure addresses a significant health problem. The Committee also agreed that while there do not appear to be potential harms associated with this measure, the potential benefits of this measure in improving the quality of care or patient outcomes are not clear, and the Committee did not recommend the measure.

Measures withdrawn by the developer and were not considered.

The following measures were withdrawn during the measure evaluation period

Measure	Measure Steward	Reason for withdrawal
0486: Adoption of Medication e-Prescribing	Centers for Medicare & Medicaid Services	Retired from the PQRS program at the end of 2008; absorbed into the Electronic Prescribing (e-RX) incentive program.
0488: Adoption of Health Information Technology	Centers for Medicare & Medicaid Services	Retired from PQRS at the end of 2012; absorbed into the Meaningful Use Program.
0489: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data Elements	Centers for Medicare & Medicaid Services	Reliability and validity data required for re-endorsement was not able to be provided.
0491: Tracking of Clinical Results Between Visits	Centers for Medicare & Medicaid Services	Reliability and validity data required for re-endorsement was not able to be provided.
0493: Participation by a physician or other clinician in systematic clinical database registry that includes consensus endorsed quality measures	Centers for Medicare & Medicaid Services	Reliability and validity data required for re-endorsement was not able to be provided.

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Measures Endorsed

Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable; Y=Yes; N=No

0291 Emergency Transfer Communication

[Submission](#) | [Specifications](#)

Description: Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that REQUIRED information was communicated to the receiving facility prior to departure (SUBSECTION 1) OR WITHIN 30 MINUTES OF TRANSFER (SUBSECTION 2-7)

Numerator Statement: Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative and clinical information was communicated to the receiving facility IN AN APPROPRIATE TIME FRAME

- EDTC-SUB 1 Administrative communication
 - Nurse to nurse communication
 - Physician to physician communication
- EDTC-SUB 2 Patient information
 - Name
 - Address
 - Age
 - Gender
 - Significant others contact information
 - Insurance
- EDTC-SUB 3 Vital signs
 - Pulse
 - Respiratory rate
 - Blood pressure
 - Oxygen saturation
 - Temperature
 - Glasgow score or other neuro assessment for trauma, cognitively altered or neuro patients only
- EDTC-SUB 4 Medication information
 - Medications administered in ED
 - Allergies
 - Home medications
- EDTC-SUB 5 Physician or practitioner generated information
 - History and physical
 - Reason for transfer and/or plan of care
- EDTC-SUB 6 Nurse generated information
 - Assessments/interventions/response
 - Sensory Status (formerly Impairments)
 - Catheters
 - Immobilizations
 - Respiratory support
 - Oral limitations
- EDTC-SUB 7 Procedures and tests

- Tests and procedures done
- Tests and procedure results sent

Denominator Statement: All emergency department patients who are transferred to another healthcare facility

Exclusions: All emergency department patients not discharged to another healthcare facility.

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry

Measure Steward: University of Minnesota Rural Health Research Center

STANDING COMMITTEE MEETING [03/18/2014- 03/19/2014]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence: 1b. Performance Gap, 1c. High Priority)

1a. Evidence: **H-0; M-0; L-1; IE-17; I-0** 1b. Performance Gap: **H-2; M-15; L-0; I-5** 1c. High Priority: **H-8; M-11; L-4; I-0**

Rationale:

- The Committee noted that the evidence presented to support the measure is based several articles and input from an expert panel. They expressed that expert opinion is not considered empirical evidence, and noted the lack of a systematic literature review, including a review of the quality, quantity and consistency of the evidence. Committee members also acknowledged the lack of evidence could be due to few of studies including rural health departments. The Committee found that the evidence presented to support the measure is insufficient, however, elected to exercise the exception to the evidence criterion, as the measure addresses a gap area, will have a high impact and the benefits of the measure outweighs potential harms.
- The Committee discussed that in terms of performance gap, the measure is intended to fill a gap in performance measurement for emergency departments in rural hospitals transferring patients to other settings.
- Committee members agreed the measures will have a high impact due to the fact that transfer of comprehensive information is critical, especially for rural hospitals that do not have other healthcare facilities nearby. However, they expressed the need for measures to go further than assessing the transfer of patient information.
- Committee members noted this measure and the other six related measures from University of Minnesota are not stratified by race, gender or ethnicity. One Committee member articulated a desire to see disparities information. The developer explained that the measures are already disparity-sensitive as rural hospitals have a higher percentage of low-income and a higher percentage of elderly patients.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-12; L-7; I-4** 2b. Validity: **H-0; M-16; L-4; I-2**

Rationale:

- The Committee agreed that reliability and validity testing were sufficient to meet the criteria. The developer performed in two field test with data from 2006, 2008, 2010 and data from 2012-2013 abstracted from paper records and EHRs. Approximately 75 rural hospitals are included in the initial rounds of testing and an additional 73 were included in the second rounds. Approximately 1500 patients were included in the first round of testing and details are not yet available for the second round of testing.
 - For field test one, for 68% of transfer records, the hospital abstractors' findings agreed 100% with the QIO staff abstraction. And in a second test, 82.4% of transfer records, the hospitals' abstraction findings agreed 100% with the QIO staff abstraction. The developer explains the number of inconsistencies in abstraction decreased by more than 50% from the first quarter to the second quarter.
 - For field test two, on-site inter-rater reliability was conducted shortly after the training. Sixty transfer records were abstracted and nearly all elements of all records matched the trainer's abstractions (statistics are not provided). The developer notes that clarification on admission dates and times was required.
 - The developer interprets these testing results to mean that initial understanding of elements was high, with little review, reinforcement or revision or clarification of the material indicated.
 - The measure's validity was determined through face validity and an expert panel used to demonstrate accord with professional standards.

3. Feasibility: H-10; M-10; L-2; I-0

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

Rationale:

- The Committee discussed the potential administrative burden of the measure due to the need to use of multiple data sources (EHR, lab and paper) to report the measure. The developer explained that the records being transferred are relatively short and there have been no complaints from implementers about burden in the implementation of this measure.

4. Use and Usability: H-7; M-12; L-0; I-3

(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)

Rationale:

- A member of the Committee questioned how the measure has been used since prior endorsement. The developer explained that as of January 2012, the state of Minnesota requires the submission of this data from all of its critical access hospitals. However, the developer does not have access to data due to privacy regulations.
- The Committee suggested that in future, the focus of the measure could be expanded to include patients transferred to additional settings, such as home health.

5. Related and Competing Measures

Standing Committee Recommendation for Endorsement: Y-16; N-6

- The Steering Committee recommended this measure for endorsement acknowledging that while communication may have occurred, it does not necessarily mean care coordination has occurred. However, the committee stated that these are small steps towards care coordination, since there are not many measures that encompass every aspect of care coordination.

6. Public and Member Comment:

Comments received:

- Several comments were posed recommending a bi-directional approach as it is difficult to confirm receipt of communication from a transferring facility prior to a patient's departure. The data element description is not clear and seems implied. Additionally, many of the methods of communication (i.e. facsimile or eDelivery) are viewed as problematic and do not warrant proof that the intended recipient has the appropriate information.

Developer response:

- This measure looks for documentation that the communication occurred. This should not be a "judgment call," either the communication is documented or it is not. This step of communication, prior to transfer is EMTALA based to ensure that the services needed are available.

Committee response:

- EMTALA is evolving and determining how it is being used is relative. The Committee continues to emphasize that bi-directional communication that closes the loop is critical in ensuring that care is coordinated.

7. Consensus Standards Approval Committee (CSAC) Review (August 12, 2014): Y-13; N-0; A-0

Decision: Approved for Continued Endorsement

CSAC and the Care Coordination Standing Committee Co-Chairs (Gerri Lamb and Don Casey) discussed the Committee's decision to exercise the evidence exception for a set of seven measures related to the transfer of patients from rural emergency departments to other facilities, and the Committee's underlying concern that the measures are intended to be reported together to communicate a comprehensive set of patient information as part of such transfers. One observation was that all of these measures address an important gap area in the communication of comprehensive information in the transfer of ED patients from rural facilities to other facilities. The measures presented were:

- *0291: Administrative Communication*
- *0292: Vital Signs*
- *0293: Medication Information*
- *0294: Patient Information*
- *0295: Physician Information*
- *0296: Nursing Information*
- *0297: Procedures and Tests*

While the Committee recommended the individual seven (7) measures for endorsement, they strongly recommended that when the developer next brings the measures to NQF for consideration, the developer should construct the measures as a single measure. The CSAC agreed with the Committee's

recommendation and requested that staff provide technical assistance to the developer to construct a comprehensive measure (measure # 0291) which encompasses all seven components. Accordingly, staff and the developer worked together to create a feasible option to consolidate the seven measures into one comprehensive measure. The CSAC reviewed the proposed changes and made a decision to approve the resulting measure for endorsement consideration. The following measures were withdrawn as separate measures and incorporated into this measure following the Committee and CSAC recommendation: #0292, 0293, 0294, 0295, 0296, and 0297.

8. NQF Board of Directors Vote: Yes (September 2, 2014)

Decision: Ratified for Continued Endorsement

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

[Submission](#) | [Specifications](#)

Description: This measure assesses the median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department

Numerator Statement: Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

Denominator Statement: Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

Exclusions: Patients who are not an ED Patient

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Outcome

Data Source: Electronic Clinical Data, Electronic Health Record

Measure Steward: Centers for Medicare and Medicaid Services

STANDING COMMITTEE MEETING [03/18/2014-03/19/2014]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)

1a. Evidence: **H-0; M-10; L-4; I-3; IE-2**; 1b. Performance Gap: **H-1; M-14; L-4; I-0**; 1c. Impact: **H-4; M-11; L-4; I-0**

Rationale:

- Committee members expressed concerns regarding the strength of the evidence presented linking Emergency Department (ED) stays and patient outcomes.
 - The developer explained that most EDs are experiencing overcrowding and that this can lead to ambulance refusals, prolonged waiting times and delays in care for patients. Reducing the time spent in the Emergency Department for admitted patients may also

mean that patients receive the specific care that they need that cannot or should not be provided in the ED sooner.

- According to studies cited by the developer, there is an overall link of ED stays with the outcomes of care. In particular, studies cited a link between longer ED stays and poor patient outcomes for specific conditions.
- Some Committee members noted that although this evidence significant, it could tend to reflect research interests. However, the Committee ultimately agreed the evidence presented is sufficient to support the measure.
- Committee members noted the trend data provided did not show improvement in performance on this measure since previous endorsement. According to the data provided, there was a difference of roughly 70 to 80 minutes in median time from ED arrival to ED departure for admitted patients, when comparing the top 10 percent with the national median. Additionally, there is no evidence of disparities in ED crowding.
 - The developer noted that the evidence clearly shows wide variation in ED wait times with room for improvement. While the data provided does not show improvement over time, that data was collected over a relatively short time window (15 months). It was suggested that examining trends over a longer period of time would show more variability in ED length of stay, although not necessarily improvement.
- Committee members agreed that this measure may help motivate improvements and potentially avoid long-term declines in performance. It addresses a high priority area and could also be an important tool for evaluating changes associated with implementation of the Affordable Care Act (ACA). As more and more patients are admitted through the ED, timeliness of care within the ED will take on greater importance in determining overall timeliness of care for admitted patients.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **N/A** 2b. Validity: **H-3; M-11; L-5; I-0**

Rationale:

- Committee members agreed that the specifications provided were clear and precise, making the measure adequate for consistent implementation.
- The Committee discussed that reliability testing was not needed because validity testing had been done at the critical data element level with good results, indicating the validity of the measure.
 - The developer explained that there were two data elements, “decision to admit time” and “ED departure time” with slightly lower agreement rates (63.29 and 76.79% respectively), due to the nature of testing time related elements, which are more prone to mismatch. The ICC statistics for these elements were very high when those time values were grouped in intervals rather than as single discrete points.
- Some Committee members conveyed uncertainty about the low kappa statistic for the data element “observation services” but noted there was a high agreement rate.
 - The developer explained that the definition of the element had been recently updated to ease abstraction from medical charts. However the impact of that change has been investigated empirically.

- Committee members noted that the strong kappa statistics for the arrival and departure time elements suggests that this is not a substantial concern, but only if the time stamps used as the gold standard comparison were a reflection of real care processes and not just an artifact of administrative processes.
- Committee members noted that the measure is not risk adjusted to account for severity of illness, and that more acute patients may require specialized care, which may not be readily available for ED admitted patients. However, the Committee ultimately agreed the validity of the measure is demonstrated.

3. Feasibility: H-12; M-7; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Committee members agreed the measure is feasible.

4. Use and Usability: H-7; M-8; L-4; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- Committee members agreed there is sufficient evidence to support public reporting (currently used in public reporting by the CMS HIQR payment program). Additionally, this measure has a strong record of widespread use, supporting its usability (currently used by the Joint Commission Accreditation program).
- Committee members agreed that this measure would be an important tool in monitoring impacts of changes in health care coverage and insurance policies.
- Committee members suggested that it is unclear how the performance results can be used to further the goal of high-quality, efficient healthcare. The data provided displayed no improvement and the developer notes that this trend may continue due to other factors (such as the expansion of state Medicaid programs). However, there do not appear to be any unintended consequences associated with the measure.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-13; N-6

6. Public and Member Comment:

Comments received:

- Recommendations were provided concerning the populations assessed within this measure, particularly patient diagnosis. In this instance, mental health as there is research that indicates treatment delays.

Developer response:

- We appreciate your support of these measures. These measures do provide the ability to drill down by mental health diagnosis, as the non-reporting strata contain cases with a mental health

diagnosis (Table 7.01 in Appendix A of the Specifications Manual). For the inpatient setting, facilities are provided with an overall rate, a reporting rate, and a rate for cases with a psychiatric diagnosis. The reporting rate excludes cases with a psychiatric diagnosis. For the outpatient setting, there is an overall rate, a reporting rate, a rate for cases with a psychiatric diagnosis, and a rate for cases that are transferred. The reporting rate excludes the cases that are transferred and those with a psychiatric diagnosis. Facilities are able to determine treatment delays for other diagnoses by calculating throughout time according to diagnoses.

Committee response:

- For quality purposes, the Committee agrees there is value in being able to access more details relative to treatment delays, by drilling down to the facility level, so that institutes may use this information and make improvements.

7. Consensus Standards Approval Committee (CSAC) Review (July 9, 2014): Y-16; N-0

Decision: Approved for Continued Endorsement

8. NQF Board of Directors Vote: Yes (September 2, 2014)

Decision: Ratified for Continued Endorsement

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

[Submission](#) | [Specifications](#)

Description: This measure assesses the median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department

Numerator Statement: Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

Denominator Statement: Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

Exclusions: Patients who expired in the emergency department

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Outcome

Data Source: Administrative claims

Measure Steward: Centers for Medicare and Medicaid Services

STANDING COMMITTEE MEETING [03/18/2014-03/19/2014]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)

1a. Evidence: **H-2; M-10; L-2; I-3; IE-2**; 1b. Performance Gap: **H-4; M-11; L-3; I-1**; 1c. Impact: **H-8; M-7; L-4; I-0**

Rationale:

- While Committee members agreed this measure is important, they were concerned that improvement was not shown for the data presented over 5 quarter in 2012 to 2013.
- Committee members found the evidence presented to support the measure compelling, and noted that there is room for improvement on the measure. Committee members reasoned that if performance is stagnating or declining, that argues for the continued importance of this measure to monitor trends and motivate further change.
 - The developer explained that although there have not been significant improvements within the metrics; there are areas of within coordination of services on the inpatient side that show improvement. The developer is working closely with the Emergency Department Benchmarking Alliance to standardize these metrics across all settings and include electronic medical records. They do also recognize this measure is somewhat dependent on Emergency Department volume. CMS, as the steward, has made the decision at least for the public display of the data, to start stratifying this performance measure by total Emergency Department annual volume, which will eventually capture a better picture of how hospitals are moving performance over time.
- This measure was identified as targeting the issue of the need to better examine/move populations through the emergency room. Committee members noted that this measure is and especially a high priority during the ACA implementation, and these are all key priority areas as we move into the new redesigned healthcare system.
 - The developer noted that the ED volume has increased between 2011 and 2012 by 3 percent to 5 percent and the acuity has increased with over 68 percent of the hospital admissions being processed through the ED. This further supports the importance of this group of patients in terms of whether there is a potential health problem.
- While the Committee agreed the measure will have a high impact, Committee members noted that additional comments were made during the workgroup call as to whether this should be a process measure focused on efficiency rather than an outcome measure.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **N/A** 2b. Validity: **H-6; M-10; L-1; I-2**

Rationale:

- Committee members agreed that the specifications provided were clear and precise, making the measure adequate for consistent implementation.
- Reliability testing was not needed because validity testing had been done at the critical data element level with good results, indicating the validity of the measure.
- Some Committee members were concerned about the low kappa statistic for the data element “observation services” but noted there was a high agreement rate.
 - The developer explained that the definition of the element had been recently updated to ease abstraction from medical charts. However the impact of that change has been not been investigated empirically.

- Committee members noted that during the workgroup calls, there was some sensitivity around exclusions surrounding the denominator. It was unclear as to who was identified in the denominator as well as those who were not in the site populations.

3. Feasibility: H-11; M-6; L-2; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Committee members agreed the measure is feasible.

4. Use and Usability: H-6; M-9; L-3; I-1

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- Committee members agreed there is sufficient evidence to support public reporting (the measure is currently used in public reporting by the CMS HIQR payment program). Additionally, this measure has a strong record of widespread use, supporting its usability (currently used by the Joint Commission Accreditation program).

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-14; N-5

6. Public and Member Comment:

Comments received:

- Commenters recommended combining measures #0495, #0496, and #0497 to create a single composite to assess the efficiency and effectiveness of emergency room processes and medical decision-making.

Developer response:

- While we understand the concerns of the Committee about the potential for unintended consequences of performance measures, we do not think it is feasible to create a “composite” measure of the three ED throughput measures. This is due to the fact that #0495 and #0496 are measures from two separating reporting programs for hospitals and also because we are not aware of any methodology for creating composites for median times.

Committee response:

- The Committee agrees with the developer’s response.

7. Consensus Standards Approval Committee (CSAC) Review (July 9, 2014): Y-16; N-0

Decision: Approved for Continued Endorsement

8. NQF Board of Directors Vote: Yes (September 2, 2014)

Decision: Ratified for Continued Endorsement

0497 Admit Decision Time to ED Departure Time for Admitted Patients

[Submission](#) | [Specifications](#)

Description: This measure assesses the median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status

Numerator Statement: Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.

Denominator Statement: Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.

Exclusions: Any ED Patient from the facility's emergency department.

Adjustment/Stratification:

Level of Analysis: Individual, Group/Practice, Facility, Health Plan

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Electronic Clinical Data : Pharmacy

Measure Steward: Centers for Medicare and Medicaid Services

STANDING COMMITTEE MEETING [03/18-19/2014]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)

1a. Evidence: **H-1; M-10; L-1; I-4; IE-1**; 1b. Performance Gap: **H-2; M-15; L-1; I-0**; 1c. Impact: **H-8; M-8; L-2; I-0**

Rationale:

- Committee members agreed that this measure speaks more directly to care coordination than 0495 and 0496, as it focuses on the time from decision to admit to actual patient discharge from the ED. The Committee noted the measure emphasizes the logistical aspects of care that occur after initial evaluation. Although Committee members noted the literature cited in support of the measure does not appear to specifically address this narrow window from decision to departure, the Committee agreed the evidence presented supports the importance of timely care and poor outcomes associated with delays in care.
- Committee members noted the lack of significant improvement in performance on the measure since prior endorsement.
 - The developer explained that although there have not been significant improvements within the metrics; there are areas of coordination of services on the inpatient side that show improvement. The developer is however, working closely with the Emergency Department Benchmarking Alliance to standardize these metrics across all settings, and include electronic medical records. The developer stated they do also recognize this measure is somewhat dependent on Emergency Department volume. CMS, as the steward, has made the decision at least for the public display of the data, to start stratifying this performance measure by total Emergency Department annual volume,

which will eventually capture a better picture of how hospitals are moving performance over time.

- The Committee accepted this explanation and agreed there is an opportunity for improvement and the measure will have a high impact.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **N/A** 2b. Validity: **H-4; M-12; L-2; I-0**

Rationale:

- Committee members agreed that the specifications provided were clear and precise, making the measure adequate for consistent implementation.
- Reliability testing was not needed because validity testing had been done at the critical data element level with good results, indicating the validity of the measure
- Some Committee members conveyed uncertainty about the low kappa statistic for the data element “observation services” but noted there was a high agreement rate
 - The developer explained that the definition of the element had been recently updated to ease abstraction from medical charts. However the impact of that change has been investigated empirically.
- Committee members discussed growth of observation units and its impact on this measure (given it was last updated in 2008).
 - The developer stated that the metrics were changed significantly recently and that there have not been any significant performance changes within this measure. However, it is difficult to predict how increased bed units would impact this measure.

3. Feasibility: H-10; M-7; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Committee members agreed the measure is feasible.

4. Use and Usability: H-7; M-11; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- Committee members agreed there is sufficient evidence to support public reporting (the measure is currently used in public reporting by the CMS HIQR payment program). Additionally, this measure has a strong record of widespread use, supporting its usability (currently used by the Joint Commission Accreditation program).

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-15; N-3

6. Public and Member Comment:

Comments received:

- Commenters recommended combining measures #0495, #0496, and #0497 to create a single composite to assess the efficiency and effectiveness of emergency room processes and medical decision-making.

Developer response:

- While we understand the concerns of the Committee about the potential for unintended consequences of performance measures, we do not think it is feasible to create a “composite” measure of the three ED throughput measures. This is due to the fact that #0495 and #0496 are measures from two separating reporting programs for hospitals and also because we are not aware of any methodology for creating composites for median times.

Committee response:

- The Committee agrees with the developer’s response.

7. Consensus Standards Approval Committee (CSAC) Review (July 9, 2014): Y-16; N-0

Decision: Approved for Continued Endorsement

8. NQF Board of Directors Vote: Yes (September 2, 2014)

Decision: Ratified for Continued Endorsement

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

[Submission](#) | [Specifications](#)

Description: This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adult

Numerator Statement: For each sampled inpatient in the denominator, the total number of unintentional medication discrepancies in admission orders plus the total number of unintentional medication discrepancies in discharge orders.

Denominator Statement: The patient denominator includes a random sample of all potential adults admitted to the hospital. Our recommendation is that 25 patients are sampled per month, or approximately 1 patient per weekday.

So, for example, if among those 25 patients, 75 unin

Exclusions: Patients that are discharged or expire before a gold standard medication list can be obtained.

Adjustment/Stratification:

Level of Analysis: Facility

Setting of Care: Hospital/Acute Care Facility

Type of Measure: Outcome

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Other, Paper Medical Records, Patient Reported Data/Survey, Electronic Clinical Data : Pharmacy

Measure Steward: Brigham and Women's Hospital

STANDING COMMITTEE MEETING [03/18/2014-03/19/2014]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)

1a. Evidence: **H-1; M-14; L-0; I-2; IE-0**; 1b. Performance Gap: **H-8; M-9; L-0; I-0**; 1c. Impact: **H-12; M-5; L-0; I-0**

Rationale:

- The Committee agreed the evidence presented provided moderate support for the measure focus. The evidence included a systematic review consisting of 26 studies consistently demonstrating that medication reconciliation interventions result in a reduction in medication discrepancies (17/17 studies), potential adverse drug events (5/6), adverse drug events (2/2), and reduction in health care utilization (2/8 studies), however the studies were of fair quality, as graded by the United States Preventive Services Task Force (USPSTF). While the Committee viewed this measure as a proxy outcome for a short-term outcome of good care coordination around medication, they did not find a strong connection between the measure and long-term error reduction and overall better patient outcomes. The Committee recommended further study to determine the long-term benefits of medication reconciliation interventions.
- The Committee concluded there is a gap in performance as the rate of unintentional medication discrepancies per patient is high and there is variation by site, with 2.78 to 4.57 discrepancies per patient (average of 3.44 per patient), making medication reconciliation errors the single biggest source of medication errors in the hospital (i.e., as opposed to errors in prescribing, transcribing, or administration).
- The Committee agreed the measure will have a high impact, as nationwide 10 percent to 67 percent of inpatients have at least one unexplained discrepancy in their prescription medication history at the time of admission; 25 percent to 71 percent have at least one medication error at discharge. Reasons for medication discrepancies among hospitalized patients are primarily: 1) "history errors," errors in taking or documenting the patient's preadmission medication history, and 2) "reconciliation errors," errors of reconciling the medication history with medication orders. In addition, approximately 70 percent of potentially harmful discrepancies are due to history errors, usually errors of omission resulting from not documenting that a patient was taking a medication prior to admission.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-2; M-14; L-1; I-0** 2b. Validity: **H-2; M-14; L-1; I-0**

Rationale:

- The Committee determined that the measure specifications were reliable and valid, noting that all codes necessary to calculate the measure were present and the specifications were

consistent with the evidence presented, however, suggested for future development the developer move past just listing medications and focus on appropriate usage.

- The Committee expressed concerns regarding the small sample size used in the testing and lack of risk adjustment done in the reliability testing. The developer explained they did take these factors into consideration but ultimately favored feasibility over reliability. Requiring extra data collection and adding to the regular work flow may cause too high of a burden on providers. The developer further explained that many training precautions were taken to assure that pharmacists at different hospitals were implementing the same process. The Committee accepted the developer's explanation and agreed that while the sample size was small, the reliability testing results are acceptable.
- Committee members agreed the measure is valid, noting validity testing was performed at the performance measure score with a systematic assessment of face validity indicated: literature is cited to support that the process of pharmacists taking pre-administration medication histories is a proxy for a gold-standard medication history.

3. Feasibility: H-1; M-10; L-5; I-1

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- While the Committee agreed the measure is feasible by a slim margin, members were unable to come to true consensus. Many members voiced concerns about the amount of extra resources required to gather the gold standard data. Several Committee members stated that the measurement burden is considerable, requiring a pharmacist trained in the measure protocol to spend time (1) creating a gold standard medication list (2) comparing the list to admission orders and (3) comparing the gold standard to discharge orders. That means actions on at least 2 different days (admission day and discharge day). In addition, creating the gold standard list will require going to several sources, including speaking with the patient or family, and potentially reaching out to providers outside the hospital. Committee members noted that this level of pharmacist involvement is not routine at most hospitals. Even at facilities where a pharmacist-generated gold standard list is a part of routine care, taking the time to compare that list to the admission and discharge orders and use the measure protocol to calculate a score is still a considerable measurement burden.
- The Committee did, however, consider whether the benefits of a substantive medication reconciliation measure outweigh this considerable measurement burden and agreed with the measure steward that this measure is a tremendous step forward in assessing the true quality of medication reconciliation, rather than relying on a "check-the-box" measure.

4. Use and Usability: H-1; M-11; L-1; I-1

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- This is a new measure and is not currently being publicly reported but a 5-year plan for use in accountability applications was presented by the developer, although a specific program was not identified. The Committee agreed with the developer that improvements in the number of

patients measured and gap in care with use of the measured intervention after 18 months were seen and the presented data was statistically significant.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-17; N-X

6. Public and Member Comment:

Comments received:

- Although supportive of this measure, there were comments that addressed the dependency on the quality of communication particularly the patient and/or caregivers' comprehensive disclosure and recall aspect as it related to existing and/or new medications, which may have implications on this measure.
- One commenter questioned the specifications within this measure stating that the population should be exclusively high-risk patients, categorized by number of medications, and severity of illness or co-morbidities.

Developer response:

- We acknowledge that patient/caregiver disclosure and recall of new and existing medications is an important data source in assembling an accurate medication history. However, because there may be limitations in the accuracy of this information (and indeed, in the accuracy of information from any source), our methods never rely on this information exclusively. As part of our methodology for completing a "gold standard" medication history with which to measure discrepancies, we require at least two independent sources of information, at least one of which must come from an entity other than a patient or caregiver. These include (but are not limited to) outpatient electronic medical record (EMR) medication lists, pharmacy prescription refill information, discharge medication lists, and non-electronic sources of information from primary care physicians and other outpatient offices and nursing facilities. These sources must be compared with each other and reviewed with patients, caregivers, and providers. We can never guarantee that the "gold standard" list is perfect, but it is as accurate as humanly possible. This methodology is highly reliable and has been performed in thousands of patients.

Committee response:

- The Committee agrees with the developer's response, and further emphasizes the importance of the patient/ caregiver voice.

7. Consensus Standards Approval Committee (CSAC) Review (July 9, 2014): Y-16; N-0

Decision: Approved for Endorsement

8. NQF Board of Directors Vote: Yes (September 2, 2014)

Decision: Ratified for Endorsement

Measures Not Endorsed

0487 EHR with EDI prescribing used in encounters where a prescribing event occurred

[Submission](#) | [Specifications](#)

Description: Of all patient encounters within the past month that used an electronic health record (EHR) with electronic data interchange (EDI) where a prescribing event occurred, how many used EDI for the prescribing event.

Numerator Statement: Number of encounters using an electronic health record (EHR) with EDI, where EDI was used for a prescribing event.

Denominator Statement: All patient encounters where medication prescribing occurred

Exclusions: 1. controlled substance(s) requiring non-EDI prescription are printed, or
2. prescriptions are printed due to patient preference for non-EDI prescription and indicated in a structured and auditable format, or
3. no prescriptions are generated during the encounter, or
4. the receiving-end of EDI transmission is inoperable and unable to receive EDI transmission at the time of prescribing

Adjustment/Stratification:

Level of Analysis: Clinician : Individual

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: Structure

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy

Measure Steward: City of New York Department of Health and Mental Hygiene

STANDING COMMITTEE MEETING [03/18-19/2014]

1. Importance to Measure and Report: The measure does not meet the Importance criteria

(1a. Evidence: 1b. Performance Gap, 1c. High Priority)

1a. Evidence: **H-X; M-X; L-X; IE-X; I-X**; 1b. Performance Gap: **H-X; M-X; L-X; I-X** 1c. High Priority: **H-X; M-X; L-X; I-X**

Rationale:

- While the Committee noted that electronic prescribing is becoming more common, potentially leading to fewer errors in dispensing than handwritten prescriptions, they agreed it is not clear that measuring the number of electronic prescriptions alone will lead to any meaningful conclusions about or improvements in quality of care. Although the developer cited several studies displaying a high prevalence of medication errors, the Committee pointed out that they do not show a clear link between the measure of the number of electronic prescription and health outcomes. Committee members encouraged the developer to provide more recent data and evidence to support measure focus given the rapid changes in the use of electronic health records in the United States.

- The Committee agreed the evidence presented was insufficient to support the measure and that there is low confidence that the measure addresses a significant health problem.
- The Committee also agreed that while there do not appear to be any potential harms associated with this measure, the potential benefits of this measure in improving the quality of care or patient outcomes are not clear, and did not recommend the measure.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-X; M-X; L-X; I-X** 2b. Validity: **H-X; M-X; L-X; I-X**

Rationale:

- N/A

3. Feasibility: H-X; M-X; L-X; I-X

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

Rationale:

- N/A

4. Use and Usability: H-X; M-X; L-X; I-X

(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)

Rationale:

- N/A

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-X; N-X

Rationale

- The Committee did not recommend this measure for endorsement since it did not pass importance, which is a must pass criteria.

6. Public and Member Comment:

Comments received:

- Commenters generally did not express support for the measure and supported the Committee's recommendation to not endorse the measure.

Measures Withdrawn from consideration

Five measures previously endorsed by NQF have not been re-submitted or withdrawn from maintenance of endorsement. The following measures are being retired from endorsement:

Measure	Reason for retirement
0486: Adoption of Medication e-Prescribing	Provider adopted a qualified e-Prescribing system and extent of use in the ambulatory setting was retired from the PQRS program at the end of 2008 and was absorbed by the Electronic Prescribing (e-RX) incentive program.
0488: Adoption of Health Information Technology	Retired from PQRS program at the end of 2012 and absorbed into the Meaningful Use Program.
0489: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR system as Discrete Searchable Data Elements	Developer was not able to provide the reliability and validity data required for re-endorsement since this measure is not validated.
0491: Tracking of Clinical Results between Visits	Developer was not able to provide the reliability and validity data required for re-endorsement since this measure is not validated.
0493: Participation by a physician or other clinician in systematic clinical database registry that include consensus endorsed quality measures	Developer was not able to provide the reliability and validity data required for re-endorsement since this measure is not validated.
0292: Vital Signs	Retired by the developer at the request of the CSAC and the Committee to condense this measure with the other six measures submitted for consideration (Measures # 0291, 0293, 0294, 0295, 0296 and 0297) into one comprehensive measure
0293: Medication Information	Retired by the developer at the request of the CSAC and the Committee to condense this measure with the other six measures submitted for consideration (Measures # 0291, 0292, 0294, 0295, 0296 and 0297) into one comprehensive measure
0294: Patient Information	Retired by the developer at the request of the CSAC and the Committee to condense this measure with the other six measures submitted for consideration (Measures # 0291, 0292, 0293, 0295, 0296 and 0297) into one comprehensive measure
0295: Physician Information	Retired by the developer at the request of the CSAC and the Committee to condense this measure with the other six measures submitted for consideration (Measures # 0291, 0292, 0293, 0294, 0296 and 0297) into one comprehensive measure.
0296: Nursing Information	Retired by the developer at the request of the CSAC and the Committee to condense this measure with the other six measures submitted for consideration (Measures # 0291, 0292, 0293, 0294, 0295 and 0297) into one comprehensive measure.
0297: Procedures and Tests	Retired by the developer at the request of the CSAC and the Committee to condense this measure with the other six measures submitted for consideration (Measures # 0291, 0292, 0293, 0294, 0295, and 0296) into one comprehensive measure

Appendix B: NQF Care Coordination Portfolio and related measures

*Denotes measures that are applicable to care coordination, but will not be evaluated in the current Care Coordination Phase 3 project.

Communication

- 0291: Emergency transfer Communication
- *0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- *0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- *0649: Transition Record with Specified Elements Received by Discharged Patients (ED Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

Information Systems

- 0487: EHR with EDI prescribing used in encounters where a prescribing event occurred

Transitions or Handoffs

- *0171: Acute care hospitalization (risk-adjusted)
- *0173: Emergency Department Use without Hospitalization
- 0495: Median time from ED arrival to ED departure for admitted ED patients
- 0496: Median time from ED arrive to ED departure for discharged ED patients
- 0497: Admit decision time to ED departure time for admitted patients
- *0526: Timely initiation of care
- *0097: Medication Reconciliation
- *0553: Care for Older Adults – Medication Review
- *0554: Medication Reconciliation Post Discharge
- *0646: Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- New, for review: *2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Healthcare Home

- *0494: Medical Home System Survey (NCQA)
- *1909: Medical Home System Survey (MHSS)

Proactive Plan of Care and Follow-Up

- *0326: Advance Care Plan

Appendix C: Care Coordination Portfolio—Use In Federal Programs

NQF #	Title	Endorsement	Federal Programs: Current Finalized 2013-2014	Federal Programs: Under Consideration 2013-2014
0228	3-Item Care Transition Measure (CTM-3)	Endorsed	Hospital Inpatient Quality Reporting	
0326	Advance Care Plan	Endorsed	Physician Feedback; Physician Quality Reporting System (PQRS)	
0489	The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/ Certified EHR System as Discrete Searchable Data Elements	Endorsed	Hospital Outpatient Quality Reporting	
0495	Median Time from ED Arrival to ED Departure for Admitted ED Patients	Endorsed	Hospital Inpatient Quality Reporting; Meaningful Use (EHR Incentive Program) - Hospitals, CAHs	
0496	Median Time from ED Arrival to ED Departure for Discharged ED Patients	Endorsed	Hospital Outpatient Quality Reporting; Meaningful Use (EHR Incentive Program) - Hospitals, CAHs	
0497	Admit Decision Time to ED Departure Time for Admitted Patients	Endorsed	Hospital Inpatient Quality Reporting; Meaningful Use (EHR Incentive Program) - Hospitals, CAHs	
0526	Timely Initiation of Care	Endorsed	Home Health Quality Reporting	
0553	Care for Older Adults- Medication Review	Endorsed	Medicare Part C plan Rating	

NQF #	Title	Endorsement	Federal Programs: Current Finalized 2013-2014	Federal Programs: Under Consideration 2013-2014
0648	Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Endorsed	Initial Core Set of health Care Quality Measures for Medicaid-Eligible Adults	

Appendix D: Project Standing Committee and NQF Staff

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Appendix E: Measure Specifications

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0291 Emergency Transfer Communication

STEWARD

University of Minnesota Rural Health Research Center

DESCRIPTION

Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that REQUIRED information was communicated to the receiving facility prior to departure (SUBSECTION 1) or WITHIN 30 MINUTES OF TRANSFER (SUBSECTION 2-7)

TYPE

Process

DATA SOURCE

Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry

LEVEL

Facility

SETTING

Hospital/Acute Care Facility

NUMERATOR STATEMENT

Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative and clinical information was communicated to the receiving facility IN AN APPROPRIATE TIME FRAME

- EDTC-SUB 1 Administrative communication
 - Nurse to nurse communication
 - Physician to physician communication
- EDTC-SUB 2 Patient information
 - Name
 - Address
 - Age
 - Gender
 - Significant others contact information
 - Insurance
- EDTC-SUB 3 Vital signs
 - Pulse
 - Respiratory rate
 - Blood pressure
 - Oxygen saturation
 - Temperature
 - Glasgow score or other neuro assessment for trauma, cognitively altered or neuro

patients only

- EDTC-SUB 4 Medication information
 - Medications administered in ED
 - Allergies
 - Home medications
- EDTC-SUB 5 Physician or practitioner generated information
 - History and physical
 - Reason for transfer and/or plan of care
- EDTC-SUB 6 Nurse generated information
 - Assessments/interventions/response
 - Sensory Status (formerly Impairments)
 - Catheters
 - Immobilizations
 - Respiratory support
 - Oral limitations
- EDTC-SUB 7 Procedures and tests
 - Tests and procedures done
 - Tests and procedure results sent

NUMERATOR DETAILS

See attachment in S.2b

DENOMINATOR STATEMENT

All emergency department patients who are transferred to another healthcare facility

DENOMINATOR DETAILS

The population of the EDTC measure set is defined by identifying patients admitted the emergency department and transferred from the emergency department to other healthcare facilities:

DC codes:

3 Hospice –healthcare facility

4a Acute Care Facility- General Inpatient Care

4b Acute Care Facility- Critical Access Hospital

4c Acute Care Facility- Cancer Hospital or Children’s Hospital

4d Acute Care Facility – Department of Defense or Veteran’s Administration

5 Other health care facility

EXCLUSIONS

All emergency department patients not discharged to another healthcare facility.

EXCLUSION DETAILS

Exclusions:

1 Home

2 Hospice-home

6 Expired

- 7 AMA (left against medical advice)
- 8 Not documented/unable to determine

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

STEWARD

Centers for Medicare and Medicaid Services

DESCRIPTION

Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department

TYPE

Outcome

DATA SOURCE

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records

LEVEL

Facility

SETTING

Hospital/Acute Care Facility

NUMERATOR STATEMENT

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

NUMERATOR DETAILS

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

DENOMINATOR STATEMENT

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

DENOMINATOR DETAILS

Any ED Patient from the facility's emergency department.

Data Element Name: ED Patient

Collected For: ED-1, ED-2

Definition: Patient received care in a dedicated emergency department of the facility.

Suggested Data Collection Question: Was the patient an ED patient at the facility?

Allowable Values:

Y (Yes) There is documentation the patient was an ED patient.

N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.

Notes for Abstraction:

- For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department.
- Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).
- Patients presenting to the ED who do not receive care or services in the ED abstract as a “No” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).
- Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a “Yes”.

ED:

- If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select “No”. This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select “No”, even if the transferred patient is seen in this facility’s ED.
- If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select “No”. This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select “No”, even if the transferred patient is seen in this facility’s ED.

Suggested Data Sources:

- Emergency department record
- Face sheet
- Registration form

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

- Urgent Care
- Fast Track ED
- Terms synonymous with Urgent Care

EXCLUSIONS

Patients who are not an ED Patient

EXCLUSION DETAILS

All non-ED patients are excluded from this measure.

Data Element Name: ED Patient

Collected For: ED-1, ED-2

Definition: Patient received care in a dedicated emergency department of the facility.
Suggested Data Collection Question: Was the patient an

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

STEWARD

Centers for Medicare and Medicaid Services

DESCRIPTION

Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department

TYPE

Outcome

DATA SOURCE

Administrative claims

LEVEL

Facility

SETTING

Hospital/Acute Care Facility

NUMERATOR STATEMENT

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

NUMERATOR DETAILS

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

DENOMINATOR STATEMENT

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

DENOMINATOR DETAILS

Any ED Patient from the facility's emergency department

E/M Codes Emergency Department

99281 Emergency department visit, new or established patient

99282 Emergency department visit, new or established patient

99283 Emergency department visit, new or established patient

99284 Emergency department visit, new or established patient

99285 Emergency department visit, new or established patient

99291 Critical care, evaluation and management

EXCLUSIONS

Patients who expired in the emergency department

EXCLUSION DETAILS

Discharge Code Value 6:Expired

0497 Admit Decision Time to ED Departure Time for Admitted Patients

STEWARD

Centers for Medicare and Medicaid Services

DESCRIPTION

Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status

TYPE

Process

DATA SOURCE

Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry

LEVEL

Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual

SETTING

Hospital/Acute Care Facility

NUMERATOR STATEMENT

Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.

Included Populations:

Any ED Patient from the facility's emergency department

NUMERATOR DETAILS

Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.

Included Populations:

Any ED Patient from the facility's emergency department

Excluded Populations:

Pa

DENOMINATOR STATEMENT

Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.

Included Populations:

Any ED Patient from the facility's emergency department

Excluded Populations:

Pa

DENOMINATOR DETAILS

Any ED Patient from the facility's emergency department.

Data Element Name: ED Patient

Collected For: ED-1, ED-2

Definition: Patient received care in a dedicated emergency department of the facility.

Suggested Data Collection Question: Was the patient an ED patient at the facility?

Allowable Values:

Y (Yes) There is documentation the patient was an ED patient.

N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.

Notes for Abstraction:

- For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department.
- Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).
- Patients presenting to the ED who do not receive care or services in the ED abstract as a "No" (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).
- Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a "Yes".

ED:

- If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select "No". This applies even if the emergency department or observation unit is part of your hospital's system (e.g., your hospital's free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select "No", even if the transferred patient is seen in this facility's ED.
- If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select "No". This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select "No", even if the transferred patient is seen in this facility's ED.

Suggested Data Sources:

- Emergency department record

- Face sheet
- Registration form

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

- Urgent Care
- Fast Track ED
- Terms synonymous with Urgent Care

EXCLUSIONS

Patients who are not an ED Patient

EXCLUSION DETAILS

All non-ED patients are excluded from this measure, with no other exclusions.

Data Element Name: ED Patient

Collected For: ED-1, ED-2

Definition: Patient received care in a dedicated emergency department of the facility.

Suggested Data Collection Que

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

STEWARD

Brigham and Women's Hospital

DESCRIPTION

This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adult

TYPE

Outcome

DATA SOURCE

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Other, Paper Medical Records, Patient Reported Data/Survey, Electronic Clinical Data : Pharmacy

LEVEL

Facility

SETTING

Hospital/Acute Care Facility

NUMERATOR STATEMENT

For each sampled inpatient in the denominator, the total number of unintentional medication discrepancies in admission orders plus the total number of unintentional medication discrepancies in discharge orders.

NUMERATOR DETAILS

First, a “gold-standard” preadmission medication history is taken by a trained study pharmacist at each site, following a strict protocol and using all available sources of information, including subject and family/caregiver interviews, prescription pill

DENOMINATOR STATEMENT

The patient denominator includes a random sample of all potential adults admitted to the hospital. Our recommendation is that 25 patients are sampled per month, or approximately 1 patient per weekday.

So, for example, if among those 25 patients, 75 unin

DENOMINATOR DETAILS

Patients are randomly selected each day from a list of admitted patients the day before. A target number of patients are selected(e.g. one patient per weekday) and these patients are interviewed by the pharmacist.

EXCLUSIONS

Patients that are discharged or expire before a gold standard medication list can be obtained.

EXCLUSION DETAILS

Please see exclusion listed above in S.10.

Appendix F1: Related and Competing Measures (tabular format)

This appendix is provided in both a tabular format and in a narrative format.

Comparison of NQF #2456, #0097, #0554, #0553, #0419, and #0646

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Steward	Brigham and Women's Hospital	National Committee for Quality Assurance	National Committee for Quality Assurance	National Committee for Quality Assurance	Centers for Medicare & Medicaid	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Description	<p>This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adult patient. The time frame is the hospitalization period.</p> <p>At the time of admission, the admission orders are compared to the preadmission medication list (PAML) compiled by trained pharmacist (i.e., the gold standard) to look for discrepancies and identify which discrepancies were unintentional using brief medical record review. This process is repeated at the time of discharge where the discharge medication list is compared to the PAML and medications ordered during the hospitalization.</p>	<p>Percentage of patients aged 18 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days of discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist who had reconciliation of the discharge medications with the current medication list in the outpatient medical record documented. This measure is reported as two rates stratified by age group: 18-64 and 65+.</p>	<p>The percentage of discharges during the first 11 months of the measurement year (e.g., January 1–December 1) for patients 65 years of age and older for whom medications were reconciled on or within 30 days of discharge.</p>	<p>Percentage of adults 65 years and older who had a medication review during the measurement year; a review of all a member’s medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.</p>	<p>Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration</p>	<p>Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories</p>
Type	Outcome	Process	Process	Process	Process	Process

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Other, Paper Medical Records, Patient Reported Data/Survey, Electronic Clinical Data : Pharmacy	Administrative claims, Electronic Clinical Data	Administrative claims, Electronic Clinical Data, Paper Medical Records	Administrative claims, Electronic Clinical Data, Paper Medical Records	Administrative claims, Electronic Clinical Data : Registry	Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records
Level	Facility	Clinician : Group/Practice, Clinician : Individual	Health Plan, Integrated Delivery System	Health Plan, Integrated Delivery System	Clinician : Individual, Population : National	Facility, Integrated Delivery System
Setting	Hospital/Acute Care Facility	Ambulatory Care : Clinician Office/Clinic, Pharmacy, Ambulatory Care : Urgent Care	Ambulatory Care : Clinician Office/Clinic, Pharmacy	Ambulatory Care : Clinician Office/Clinic, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Other, Behavioral Health/Psychiatric : Outpatient	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation
Numerator Statement	For each sampled inpatient in the denominator, the total number of unintentional medication discrepancies in admission orders plus the total number of unintentional medication discrepancies in discharge orders.	Patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented* *The medical record must indicate that the physician, prescribing practitioner, registered nurse, or clinical pharmacist is aware of the inpatient facility discharge medications and will reconcile the list with the current medications list in the medical record.	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge.	At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record.	ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION. Eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route NUMERATOR NOTE: By reporting G8427, the eligible professional is attesting the documented medication	Patients or their caregiver(s) who received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories: Medications to be TAKEN by patient: - Continued* Medications prescribed before inpatient stay that patient should continue to take after discharge, including any change in dosage or directions AND - New* Medications started during inpatient stay that are to be continued after discharge and newly prescribed

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
					information is current, accurate and complete to the best of his/her knowledge and ability at the time of the patient encounter. This code should also be reported if the eligible professional documented that the patient is not currently taking any medications. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.	medications that patient should begin taking after discharge * Prescribed dosage, instructions, and intended duration must be included for each continued and new medication listed Medications NOT to be Taken by patient: - Discontinued Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND - Allergies and Adverse Reactions Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued
Numerator Details	First, a “gold-standard” preadmission medication history is taken by a trained study pharmacist at each site, following a strict protocol and using all available sources of information, including subject and family/caregiver interviews, prescription pill bottles, outpatient electronic medical records, hard copies of forms/patient lists, previous hospital discharge orders, outpatient providers, and outpatient pharmacies (see Appendix A for complete protocol). The resulting	CPT Category II code 1111F: Discharge medications reconciled with the current medication list in the outpatient medical record documented.	Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record, on or within 30 days after discharge. ADMINISTRATIVE Medication reconciliation conducted by prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. - See corresponding Excel document for the Medication Reconciliation	ADMINISTRATIVE Any of the following meet criteria: Both of the following on the same date of service during the measurement year: – At least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist. – The presence of a medication list in the medical record (Medication List Value Set). Transitional care management	G-codes are defined as Quality Data Codes (QDCs), which are subset of HCPCS II codes. QDCs are non billable codes that providers will use to delineate their clinical quality actions, which are submitted with Medicare Part B Claims. There are three different G-code options for NQF measure #0419 Current Medications Documented G8427: Eligible professional attests to documenting the patient’s current medications to the best of his/her knowledge and ability OR	Numerator Definitions: • For the purposes of this measure, “medications” includes prescription, over-the-counter, and herbal products. Generic and proprietary names should be provided for each medication, when available. • Given the complexity of the medication reconciliation process and variability across inpatient facilities in documentation of that process, this measure does not require that the medication list be organized under the “taken/NOT taken” headings OR the specified sub-categories, provided that the status of each medication

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	<p>preadmission medication list is then compared with the medical team’s documented preadmission medication list and with all admission and discharge medication orders. Any discrepancies between the gold-standard history and medication orders are identified and reasons for these changes sought from the medical record. Pharmacists may also need to communicate directly with the medical team to clarify reasons for discrepancies, as needed. Medication discrepancies that are not clearly intentional are then recorded, along with the reason for the discrepancy:</p> <ol style="list-style-type: none"> History error: the order is incorrect because the medical team’s preadmission medication list is incorrect (e.g., the team did not know the patient was taking aspirin prior to admission, does not record it in the preadmission medication list, and therefore does not order it at admission) Reconciliation error: the medical team’s preadmission medication list is correct, but there is still an error in the orders. For example, the team knew the patient was taking aspirin prior to admission and documents it in the preadmission medication list. The team decides to hold the aspirin on admission for a clinical reason 		<p>Value Set ---</p> <p>MEDICAL RECORD</p> <p>Documentation in the medical record must include evidence of medication reconciliation, and the date on which it was performed. The following evidence meets criteria:</p> <ul style="list-style-type: none"> • Notation that medications prescribed or ordered upon discharge were reconciled with the current medications (in outpatient record) by the appropriate practitioner type, or • A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications conducted by an appropriate practitioner type (the organization must be able to distinguish between the patient’s discharge medications and the patient’s current medications). or • Notation that no medications were prescribed or ordered upon discharge <p>Only documentation in the outpatient chart meets the intent of the measure, but an in-person, outpatient visit is not required</p>	<p>services (TCM 7 Day Value Set) where the reported date of service on the claim is on or between January 30 of the measurement year and January 22 of the year after the measurement year.</p> <p>Transitional care management services (TCM 14 Day Value Set) where the reported date of service on the claim is on or between January 30 of the measurement year and January 15 of the year after the measurement year.</p> <p>(See corresponding Excel document for the value sets referenced above)</p> <p>Note: Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit. Medication reconciliation and management must be furnished no later than the date of the face-to-face visit.</p> <p>---</p> <p>MEDICAL RECORD</p> <p>Documentation must come from the same medical record and must include the following:</p>	<p>Current Medications not Documented, Patient not Eligible</p> <p>G8430: Eligible professional attests the patient is not eligible for medication documentation</p> <p>OR</p> <p>Current Medications with Name, Dosage, Frequency, Route not Documented, Reason not Given</p> <p>G8428: Current medications not documented by the eligible professional, reason not given.</p> <p>Definitions:</p> <p>Current Medications – Medications the patient is presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication’s name, dosage, frequency and administered route.</p>	<p>(continued, new, or discontinued) is specified within the list AND any allergic reactions are identified.</p> <p>For EHR:</p> <p>This measure does not lend itself to a “traditional specification” for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for medication reconciliation and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.</p> <p>Producing the Reconciled Medication List</p> <p>Facilities that have implemented an EHR system should utilize their system to develop a standardized template for the Reconciled Medication List. A standardized template will ensure that all required data elements specified in the measure are included whenever a Reconciled Medication List is generated from the EHR. Each facility has the autonomy to customize the format of the</p> <p>Reconciled Medication List, based on clinical workflow, policies and procedures, and the patient</p>

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
	<p>such as bleeding, but the team forgets to restart the aspirin at discharge. The admission discrepancy would be considered intentional (no error, not counted in the numerator), but the discharge discrepancy would be counted as a reconciliation error. The type of error should also be recorded: omission, discrepancy in dose, route, frequency, or formulation, or an additional medication.</p> <p>Lastly, the time of the error should be recorded: admission vs. discharge.</p>			<ul style="list-style-type: none"> • A medication list in the medical record, AND evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed • Notation that the patient is not taking any medication and the date when it was noted <p>A review of side effects for a single medication at the time of prescription alone is not sufficient.</p> <p>An outpatient visit is not required to meet criteria.</p> <p>Prescribing practitioner is defined as a practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.</p>		<p>population treated at the individual institution.</p> <p>Systematic External Reporting that the Reconciled Medication List was provided to patient</p> <p>In order to report, at the facility level, which of the discharged patients have received a Reconciled Medication List, a discrete data field and code indicating the patient received a reconciled medication list at discharge may be needed in the EHR. Each facility should determine the most effective way to identify whether or not the patient received the reconciled medication list.</p> <p>Transmitting the Reconciled Medication List</p> <p>This performance measure does not require that the Reconciled Medication List be transmitted to the next provider(s) of care. However, if it is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model, developed by the National Quality Forum. RxNorm has been named as the recommended vocabulary for medications and can be used to identify the medications to</p>

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
						<p>which the allergies exist. Allergies (non-substance) and Adverse Events to medications should be expressed using SNOMED-CT. The use of industry standards for the transmission of the Reconciled Medication List information will ensure that the information can be received into the destination EHR.</p> <p>For Claims/Administrative: Numerator Action to be identified through medical record abstraction: See Sample Data Collection Tool attached.</p>
Denominator Statement	<p>The patient denominator includes a random sample of all potential adults admitted to the hospital. Our recommendation is that 25 patients are sampled per month, or approximately 1 patient per weekday.</p> <p>So, for example, if among those 25 patients, 75 unintentional discrepancies are identified, the measure outcome would be 3 discrepancies per patient for that hospital for that month.</p>	All patients aged 18 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care. This measure is reported as two rates with age-specific denominators: 18-64 and 65+.	Patients who are 66 years and older as of the end of the measurement year with an acute or nonacute inpatient discharge during the first 11 months of the measurement year (e.g., January 1 to December 1).	All patients 66 and older as of the end (e.g., December 31) of the measurement year.	<p>ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.</p> <p>All visits occurring during the 12 month reporting period for patients aged 18 years and older on the date of the encounter where one or more CPT or HCPCS codes are reported on the claims submission for that encounter. All discussed coding is listed in "2a1.7. Denominator Details" section below.</p>	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.
Denominator Details	Patients are randomly selected each day from a list of admitted patients the day before. A target number of patients are selected(e.g. one patient per weekday) and these patients are interviewed by the pharmacist.	<p>CPT service codes:</p> <p>90791, 90792, 90832,90834, 90837, 90839, 90845, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99238, 99239, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335,</p>	<p>ADMINISTRATIVE</p> <p>An acute or nonacute inpatient discharge during the first 11 months of the measurement year (e.g., January 1 to December 1). The denominator is based on episodes, not patients. Patients may appear more than once in the denominator.</p>	Use administrative data to identify all patients 66 years and older as of the end of the measurement year.	For the purposes of defining the denominator, the Performance Denominator(PD) is defined by the patient's age, encounter date, denominator CPT or HCPCS codes and the provider reported numerator HCPCS codes described below (G8427, G8430 & G8428).	For EHR: Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
		<p>99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350</p> <p>AND</p> <p>CPT Category II code 1110F: Patient discharged from an inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) within the last 30 days.</p>	<p>If patients have more than one discharge, include all discharges during the first 11 months of the measurement year.</p> <p>If the discharge is followed by a readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, count the only the readmission discharge or the discharge from the facility to which the patient was transferred.</p> <p>Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after the first 11 months of the measurement year (e.g., December 1).</p> <p>---</p> <p>MEDICAL RECORD</p> <p>Same as ADMINISTRATIVE. The denominator is based on the discharge date found in the administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections.</p>		<p>Patient encounter during the reporting period (CPT or HCPCS):</p> <p>90791, 90792, 90832, 90834, 90837, 90839, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0270, G0402, G0438, G0439</p>	<p>For Claims/Administrative:</p> <p>Identify patients discharged from inpatient facility using the following:</p> <p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0111 (Hospital, Inpatient, Admit through Discharge Claim) • 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim) • 0114 (Hospital, Inpatient, Last Claim) • 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim) • 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient, Interim, Last Claim) • 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim) • 0224 (Skilled Nursing- Interim, Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
						<p>nursing facility (SNF) with Medicare certification in anticipation of skilled care)</p> <ul style="list-style-type: none">• 04 (Discharged/transferred to an intermediate care facility)• 05 Discharged/transferred to a designated cancer center or children’s hospital• 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care)• 43 (Discharged/transferred to a federal health care facility)• 50 (Hospice – home)• 51 (Hospice - medical facility (certified) providing hospice level of care)• 61 (Discharged/transferred to hospital-based Medicare approved swing bed)• 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)• 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))• 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)• 65 (Discharged/transferred to a psychiatric hospital or psychiatric

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
						<p>distinct part unit of a hospital)</p> <ul style="list-style-type: none"> • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) <p>OR</p> <p>UB-04 (Form Locator 04 - Type of Bill):</p> <ul style="list-style-type: none"> • 0131 (Hospital Outpatient, Admit through Discharge Claim) • 0134 (Hospital Outpatient, Interim, Last Claim) <p>AND</p> <p>UB-04 (Form Locator 42 - Revenue Code):</p> <ul style="list-style-type: none"> • 0762 (Hospital Observation) • 0490 (Ambulatory Surgery) • 0499 (Other Ambulatory Surgery) <p>AND</p> <p>Discharge Status (Form Locator 17)</p> <ul style="list-style-type: none"> • 01 (Discharged to home care or self care (routine discharge)) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to an intermediate care facility) • 05 Discharged/transferred to a

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
						<p>designated cancer center or children’s hospital</p> <ul style="list-style-type: none"> • 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care) • 43 (Discharged/transferred to a federal health care facility) • 50 (Hospice – home) • 51 (Hospice - medical facility (certified) providing hospice level of care) • 61 (Discharged/transferred to hospital-based Medicare approved swing bed) • 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital) • 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH)) • 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare) • 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) • 66 (Discharged/transferred to a Critical Access Hospital (CAH)) • 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Exclusions	Patients that are discharged or expire before a gold standard medication list can be obtained.	N/A	N/A	N/A	<p>ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.</p> <p>A patient is not eligible or excluded (B) from the performance denominator (PD) if one or more of the following reason exists:</p> <ul style="list-style-type: none">• Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.	<p>Patients who died</p> <p>Patients who left against medical advice (AMA) or discontinued care</p>

	2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	0097 Medication Reconciliation	0554 Medication Reconciliation Post-Discharge (MRP)	0553 Care for Older Adults (COA) – Medication Review	0419 Documentation of Current Medications in the Medical Record	0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Exclusion Details	Please see exclusion listed above in S.10.	N/A	N/A	N/A	<p>For the purposes of identifying performance exclusions, Denominator Exclusions (B) are defined by providers reporting the exclusion clinical quality action. For this measure, the clinical exclusion code is numerator HCPCS G8430.</p> <p>Current Medications not Documented, Patient not Eligible</p> <p>G8430: Eligible professional attests the patient is not eligible for medication documentation</p>	<p>The PCPI methodology uses three categories of reasons for which a patient may be excluded 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. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. 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 example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception.</p>

Comparison of NQF #0495, #0496 and #0497

	0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients	0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients	0497 Admit Decision Time to ED Departure Time for Admitted Patients
Steward	Centers for Medicare & Medicaid	Centers for Medicare & Medicaid	Centers for Medicare & Medicaid
Description	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department	Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department	Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status
Type	Outcome	Process	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records
Level	Facility	Facility	Facility
Setting	Hospital/Acute Care Facility	Hospital/Acute Care Facility	Hospital/Acute Care Facility
Numerator Statement	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.	Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients. Included Populations: Any ED Patient from the facility’s emergency department
Numerator Details	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.	Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients. Included Populations: Any ED Patient from the facility’s emergency department Excluded Populations: Patients who are not an ED Patient Data Elements: <ul style="list-style-type: none">Decision to Admit DateDecision to Admit TimeED Departure DateED Departure TimeED PatientICD-9-CM Principal Diagnosis Code

	0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients	0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients	0497 Admit Decision Time to ED Departure Time for Admitted Patients
Denominator Statement	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.	Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients. Included Populations: Any ED Patient from the facility's emergency department Excluded Populations: Patients who are not an ED Patient Data Elements: <ul style="list-style-type: none"> Decision to Admit Date Decision to Admit Time ED Departure Date ED Departure Time ED Patient ICD-9-CM Principal Diagnosis Code
Denominator Details	Any ED Patient from the facility's emergency department. Data Element Name: ED Patient Collected For: ED-1, ED-2 Definition: Patient received care in a dedicated emergency department of the facility. Suggested Data Collection Question: Was the patient an ED patient at the facility? Allowable Values: Y (Yes) There is documentation the patient was an ED patient. N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation. Notes for Abstraction: <ul style="list-style-type: none"> For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department. Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and 	Any ED Patient from the facility's emergency department E/M Codes Emergency Department 99281 Emergency department visit, new or established patient 99282 Emergency department visit, new or established patient 99283 Emergency department visit, new or established patient 99284 Emergency department visit, new or established patient 99285 Emergency department visit, new or established patient 99291 Critical care, evaluation and management	Any ED Patient from the facility's emergency department. Data Element Name: ED Patient Collected For: ED-1, ED-2 Definition: Patient received care in a dedicated emergency department of the facility. Suggested Data Collection Question: Was the patient an ED patient at the facility? Allowable Values: Y (Yes) There is documentation the patient was an ED patient. N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation. Notes for Abstraction: <ul style="list-style-type: none"> For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department. Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred

	0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients	0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients	0497 Admit Decision Time to ED Departure Time for Admitted Patients
	<p>transferred to the hospital as a direct admit would not be considered an ED patient).</p> <ul style="list-style-type: none">• Patients presenting to the ED who do not receive care or services in the ED abstract as a “No” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).• Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a “Yes”. <p>ED:</p> <ul style="list-style-type: none">• If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select “No”. This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select “No”, even if the transferred patient is seen in this facility’s ED.• If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select “No”. This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select “No”, even if the transferred patient is seen in this facility’s ED. <p>Suggested Data Sources:</p> <ul style="list-style-type: none">• Emergency department record• Face sheet• Registration form <p>Inclusion Guidelines for Abstraction:</p> <p>None</p> <p>Exclusion Guidelines for Abstraction:</p> <ul style="list-style-type: none">• Urgent Care• Fast Track ED• Terms synonymous with Urgent Care		<p>to the hospital as a direct admit would not be considered an ED patient).</p> <ul style="list-style-type: none">• Patients presenting to the ED who do not receive care or services in the ED abstract as a “No” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).• Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a “Yes”. <p>ED:</p> <ul style="list-style-type: none">• If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select “No”. This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select “No”, even if the transferred patient is seen in this facility’s ED.• If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select “No”. This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select “No”, even if the transferred patient is seen in this facility’s ED. <p>Suggested Data Sources:</p> <ul style="list-style-type: none">• Emergency department record• Face sheet• Registration form <p>Inclusion Guidelines for Abstraction:</p> <p>None</p> <p>Exclusion Guidelines for Abstraction:</p> <ul style="list-style-type: none">• Urgent Care• Fast Track ED• Terms synonymous with Urgent Care
Exclusions	Patients who are not an ED Patient	Patients who expired in the emergency department	Patients who are not an ED Patient
Exclusion Details	All non-ED patients are excluded from this measure. Data Element Name: ED Patient	Discharge Code Value 6:Expired	All non-ED patients are excluded from this measure, with no other exclusions.

	0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients	0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients	0497 Admit Decision Time to ED Departure Time for Admitted Patients
	<p>Collected For: ED-1, ED-2</p> <p>Definition: Patient received care in a dedicated emergency department of the facility.</p> <p>Suggested Data Collection Question: Was the patient an ED patient at the facility?</p> <p>Allowable Values:</p> <p>Y (Yes) There is documentation the patient was an ED patient.</p> <p>N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.</p> <p>Notes for Abstraction:</p> <ul style="list-style-type: none">• For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department.• Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).• Patients presenting to the ED who do not receive care or services in the ED abstract as a “No” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).• Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a “Yes”. <p>ED:</p> <ul style="list-style-type: none">• If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select “No”. This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select “No”, even if the transferred patient is seen in this facility’s ED.• If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select “No”. This applies even if the two hospitals are close in proximity, part of the		<p>Data Element Name: ED Patient</p> <p>Collected For: ED-1, ED-2</p> <p>Definition: Patient received care in a dedicated emergency department of the facility.</p> <p>Suggested Data Collection Question: Was the patient an ED patient at the facility?</p> <p>Allowable Values:</p> <p>Y (Yes) There is documentation the patient was an ED patient.</p> <p>N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.</p> <p>Notes for Abstraction:</p> <ul style="list-style-type: none">• For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department.• Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).• Patients presenting to the ED who do not receive care or services in the ED abstract as a “No” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).• Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a “Yes”. <p>ED:</p> <ul style="list-style-type: none">• If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select “No”. This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select “No”, even if the transferred patient is seen in this facility’s ED.• If the patient is transferred to your hospital from an outside

	0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients	0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients	0497 Admit Decision Time to ED Departure Time for Admitted Patients
	<p>same hospital system, have the same provider number, and/or there is one medical record. Select “No”, even if the transferred patient is seen in this facility’s ED.</p> <p>Suggested Data Sources:</p> <ul style="list-style-type: none">Emergency department recordFace sheetRegistration form <p>Inclusion Guidelines for Abstraction:</p> <p>None</p> <p>Exclusion Guidelines for Abstraction:</p> <ul style="list-style-type: none">Urgent CareFast Track EDTerms synonymous with Urgent Care		<p>hospital where he was an inpatient or outpatient, select “No”. This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select “No”, even if the transferred patient is seen in this facility’s ED.</p> <p>Suggested Data Sources:</p> <ul style="list-style-type: none">Emergency department recordFace sheetRegistration form <p>Inclusion Guidelines for Abstraction:</p> <p>None</p> <p>Exclusion Guidelines for Abstraction:</p> <ul style="list-style-type: none">Urgent CareFast Track EDTerms synonymous with Urgent Care

Appendix F2: Related and Competing Measures (narrative format)

This appendix is provided in both a tabular format and in a narrative format.

Comparison of NQF #2456, #0097, #0554, #0553, #0419, and #0646

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

0097 Medication Reconciliation

0554 Medication Reconciliation Post-Discharge (MRP)

0553 Care for Older Adults (COA) – Medication Review

0419 Documentation of Current Medications in the Medical Record

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Steward

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Brigham and Women's Hospital

0097 Medication Reconciliation

National Committee for Quality Assurance

0554 Medication Reconciliation Post-Discharge (MRP)

National Committee for Quality Assurance

0553 Care for Older Adults (COA) – Medication Review

National Committee for Quality Assurance

0419 Documentation of Current Medications in the Medical Record

Centers for Medicare & Medicaid

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

Description

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adult patient. The time frame is the hospitalization period.

At the time of admission, the admission orders are compared to the preadmission medication list (PAML) compiled by trained pharmacist (i.e., the gold standard) to look for discrepancies and identify which discrepancies were unintentional using brief medical record review. This process is repeated at the time of discharge where the discharge medication list is compared to the PAML and medications ordered during the hospitalization.

0097 Medication Reconciliation

Percentage of patients aged 18 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days of discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist who had reconciliation of the discharge medications with the current medication list in the outpatient medical record documented. This measure is reported as two rates stratified by age group: 18-64 and 65+.

0554 Medication Reconciliation Post-Discharge (MRP)

The percentage of discharges during the first 11 months of the measurement year (e.g., January 1–December 1) for patients 65 years of age and older for whom medications were reconciled on or within 30 days of discharge.

0553 Care for Older Adults (COA) – Medication Review

Percentage of adults 65 years and older who had a medication review during the measurement year; a review of all a member's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.

0419 Documentation of Current Medications in the Medical Record

Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories

Type

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Outcome

0097 Medication Reconciliation

Process

0554 Medication Reconciliation Post-Discharge (MRP)

Process

0553 Care for Older Adults (COA) – Medication Review

Process

0419 Documentation of Current Medications in the Medical Record

Process

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Process

Data Source

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Other, Paper Medical Records, Patient Reported Data/Survey, Electronic Clinical Data : Pharmacy

0097 Medication Reconciliation

Administrative claims, Electronic Clinical Data

0554 Medication Reconciliation Post-Discharge (MRP)

Administrative claims, Electronic Clinical Data, Paper Medical Records

0553 Care for Older Adults (COA) – Medication Review

Administrative claims, Electronic Clinical Data, Paper Medical Records

0419 Documentation of Current Medications in the Medical Record

Administrative claims, Electronic Clinical Data : Registry

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Records

Level

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Facility

0097 Medication Reconciliation

Clinician : Group/Practice, Clinician : Individual

0554 Medication Reconciliation Post-Discharge (MRP)

Health Plan, Integrated Delivery System

0553 Care for Older Adults (COA) – Medication Review

Health Plan, Integrated Delivery System

0419 Documentation of Current Medications in the Medical Record

Clinician : Individual, Population : National

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Facility, Integrated Delivery System

Setting

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Hospital/Acute Care Facility

0097 Medication Reconciliation

Ambulatory Care : Clinician Office/Clinic, Pharmacy, Ambulatory Care : Urgent Care

0554 Medication Reconciliation Post-Discharge (MRP)

Ambulatory Care : Clinician Office/Clinic, Pharmacy

0553 Care for Older Adults (COA) – Medication Review

Ambulatory Care : Clinician Office/Clinic, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

0419 Documentation of Current Medications in the Medical Record

Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Other, Behavioral Health/Psychiatric : Outpatient

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post Acute/Long Term Care Facility : Rehabilitation

*Numerator Statement***2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient**

For each sampled inpatient in the denominator, the total number of unintentional medication discrepancies in admission orders plus the total number of unintentional medication discrepancies in discharge orders.

0097 Medication Reconciliation

Patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented*

*The medical record must indicate that the physician, prescribing practitioner, registered nurse, or clinical pharmacist is aware of the inpatient facility discharge medications and will reconcile the list with the current medications list in the medical record.

0554 Medication Reconciliation Post-Discharge (MRP)

Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge.

0553 Care for Older Adults (COA) – Medication Review

At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record.

0419 Documentation of Current Medications in the Medical Record

ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.

Eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the counters,

herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route

NUMERATOR NOTE: By reporting G8427, the eligible professional is attesting the documented medication information is current, accurate and complete to the best of his/her knowledge and ability at the time of the patient encounter. This code should also be reported if the eligible professional documented that the patient is not currently taking any medications. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Patients or their caregiver(s) who received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories:

Medications to be TAKEN by patient:

- Continued*

Medications prescribed before inpatient stay that patient should continue to take after discharge, including any change in dosage or directions AND

- New*

Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge

* Prescribed dosage, instructions, and intended duration must be included for each continued and new medication listed

Medications NOT to be Taken by patient:

- Discontinued

Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND

- Allergies and Adverse Reactions

Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued

Numerator Details

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

First, a "gold-standard" preadmission medication history is taken by a trained study pharmacist at each site, following a strict protocol and using all available sources of information, including subject and family/caregiver interviews, prescription pill bottles, outpatient electronic medical records, hard copies of forms/patient lists, previous hospital discharge orders, outpatient providers, and outpatient pharmacies (see Appendix A for complete protocol). The resulting preadmission medication list is then compared with the medical team's documented preadmission medication list and with all admission and discharge medication orders. Any discrepancies between the gold-standard history and medication orders are identified and reasons for these changes sought from the medical record. Pharmacists may also need to communicate directly with the medical team to clarify reasons for discrepancies, as needed. Medication discrepancies that are not clearly intentional are then recorded, along with the reason for the discrepancy:

1. History error: the order is incorrect because the medical team's preadmission medication list is incorrect (e.g., the team did not know the patient was taking aspirin prior to admission, does not record it in the preadmission medication list, and therefore does not order it at admission)

2. Reconciliation error: the medical team's preadmission medication list is correct, but there is still an error in the orders. For example, the team knew the patient was taking aspirin prior to admission and documents it in the preadmission medication list. The team decides to hold the aspirin on admission for a clinical reason such as bleeding, but the team forgets to restart the aspirin at discharge. The admission discrepancy would be considered intentional (no error, not counted in the numerator), but the discharge discrepancy would be counted as a reconciliation error.

The type of error should also be recorded: omission, discrepancy in dose, route, frequency, or formulation, or an additional medication.

Lastly, the time of the error should be recorded: admission vs. discharge.

0097 Medication Reconciliation

CPT Category II code 1111F: Discharge medications reconciled with the current medication list in the outpatient medical record documented.

0554 Medication Reconciliation Post-Discharge (MRP)

Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record, on or within 30 days after discharge.

ADMINISTRATIVE

Medication reconciliation conducted by prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge.

- See corresponding Excel document for the Medication Reconciliation Value Set

MEDICAL RECORD

Documentation in the medical record must include evidence of medication reconciliation, and the date on which it was performed. The following evidence meets criteria:

- Notation that medications prescribed or ordered upon discharge were reconciled with the current medications (in outpatient record) by the appropriate practitioner type, or
- A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications conducted by an appropriate practitioner type (the organization must be able to distinguish between the patient's discharge medications and the patient's current medications). or
- Notation that no medications were prescribed or ordered upon discharge

Only documentation in the outpatient chart meets the intent of the measure, but an in-person, outpatient visit is not required

0553 Care for Older Adults (COA) – Medication Review

ADMINISTRATIVE

Any of the following meet criteria:

Both of the following on the same date of service during the measurement year:

- At least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist.
- The presence of a medication list in the medical record (Medication List Value Set).

Transitional care management services (TCM 7 Day Value Set) where the reported date of service on the claim is on or between January 30 of the measurement year and January 22 of the year after the measurement year.

Transitional care management services (TCM 14 Day Value Set) where the reported date of service on the claim is on or between January 30 of the measurement year and January 15 of the year after the measurement year.

(See corresponding Excel document for the value sets referenced above)

Note: Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit. Medication reconciliation and management must be furnished no later than the date of the face-to-face visit.

MEDICAL RECORD

Documentation must come from the same medical record and must include the following:

- A medication list in the medical record, AND evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed
- Notation that the patient is not taking any medication and the date when it was noted

A review of side effects for a single medication at the time of prescription alone is not sufficient.

An outpatient visit is not required to meet criteria.

Prescribing practitioner is defined as a practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.

0419 Documentation of Current Medications in the Medical Record

G-codes are defined as Quality Data Codes (QDCs), which are a subset of HCPCs II codes. QDCs are non-billable codes that providers will use to delineate their clinical quality actions, which are submitted with Medicare Part B Claims. There are three different G-code options for NQF measure #0419

Current Medications Documented

G8427: Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability

OR

Current Medications not Documented, Patient not Eligible

G8430: Eligible professional attests the patient is not eligible for medication documentation

OR

Current Medications with Name, Dosage, Frequency, Route not Documented, Reason not Given

G8428: Current medications not documented by the eligible professional, reason not given.

Definitions:

Current Medications – Medications the patient is presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route.

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Numerator Definitions:

- For the purposes of this measure, “medications” includes prescription, over-the-counter, and herbal products. Generic and proprietary names should be provided for each medication, when available.
- Given the complexity of the medication reconciliation process and variability across inpatient facilities in documentation of that process, this measure does not require that the medication list be organized under the “taken/NOT taken” headings OR the specified sub-categories, provided that the status of each medication (continued, new, or discontinued) is specified within the list AND any allergic reactions are identified.

For EHR:

This measure does not lend itself to a “traditional specification” for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for medication reconciliation and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.

Producing the Reconciled Medication List

Facilities that have implemented an EHR system should utilize their system to develop a standardized template for the Reconciled Medication List. A standardized template will ensure that all required data elements specified in the measure are included whenever a Reconciled Medication List is generated from the EHR. Each facility has the autonomy to customize the format of the

Reconciled Medication List, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution.

Systematic External Reporting that the Reconciled Medication List was provided to patient

In order to report, at the facility level, which of the discharged patients have received a Reconciled Medication List, a discrete data field and code indicating the patient received a reconciled medication list at discharge may be needed in the EHR. Each facility should determine the most effective way to identify whether or not the patient received the reconciled medication list.

Transmitting the Reconciled Medication List

This performance measure does not require that the Reconciled Medication List be transmitted to the next provider(s) of care. However, if it is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model, developed by the National Quality Forum.

RxNorm has been named as the recommended vocabulary for medications and can be

used to identify the medications to which the allergies exist. Allergies (non-substance) and Adverse Events to medications should be expressed using SNOMED-CT. The use of industry standards for the transmission of the Reconciled Medication List information will ensure that the information can be received into the destination EHR.

For Claims/Administrative:

Numerator Action to be identified through medical record abstraction: See Sample Data Collection Tool attached.

Denominator Statement

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

The patient denominator includes a random sample of all potential adults admitted to the hospital. Our recommendation is that 25 patients are sampled per month, or approximately 1 patient per weekday.

So, for example, if among those 25 patients, 75 unintentional discrepancies are identified, the measure outcome would be 3 discrepancies per patient for that hospital for that month.

0097 Medication Reconciliation

All patients aged 18 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care. This measure is reported as two rates with age-specific denominators: 18-64 and 65+.

0554 Medication Reconciliation Post-Discharge (MRP)

Patients who are 66 years and older as of the end of the measurement year with an acute or nonacute inpatient discharge during the first 11 months of the measurement year (e.g., January 1 to December 1).

0553 Care for Older Adults (COA) – Medication Review

All patients 66 and older as of the end (e.g., December 31) of the measurement year.

0419 Documentation of Current Medications in the Medical Record

ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.

All visits occurring during the 12 month reporting period for patients aged 18 years and older on the date of the encounter where one or more CPT or HCPCS codes are reported on the claims submission for that encounter. All discussed coding is listed in "2a1.7.

Denominator Details" section below.

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.

Denominator Details

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Patients are randomly selected each day from a list of admitted patients the day before. A target number of patients are selected(e.g. one patient per weekday) and these patients are interviewed by the pharmacist.

0097 Medication Reconciliation

CPT service codes:

90791, 90792, 90832, 90834, 90837, 90839, 90845, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99238, 99239, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

AND

CPT Category II code 1110F: Patient discharged from an inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) within the last 30 days.

0554 Medication Reconciliation Post-Discharge (MRP)

ADMINISTRATIVE

An acute or nonacute inpatient discharge during the first 11 months of the measurement year (e.g., January 1 to December 1). The denominator is based on episodes, not patients. Patients may appear more than once in the denominator. If patients have more than one discharge, include all discharges during the first 11 months of the measurement year.

If the discharge is followed by a readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, count the only the readmission discharge or the discharge from the facility to which the patient was transferred.

Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after the first 11 months of the measurement year (e.g., December 1).

MEDICAL RECORD

Same as ADMINISTRATIVE. The denominator is based on the discharge date found in the administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections.

0553 Care for Older Adults (COA) – Medication Review

Use administrative data to identify all patients 66 years and older as of the end of the measurement year.

0419 Documentation of Current Medications in the Medical Record

For the purposes of defining the denominator, the Performance Denominator(PD) is defined by the patient's age, encounter date, denominator CPT or HCPCS codes and the provider reported numerator HCPCS codes described below (G8427, G8430 & G8428).

Patient encounter during the reporting period (CPT or HCPCS):

90791, 90792, 90832, 90834, 90837, 90839, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92541, 92542, 92543, 92544,

92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0270, G0402, G0438, G0439

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

For EHR:

Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.

For Claims/Administrative:

Identify patients discharged from inpatient facility using the following:

UB-04 (Form Locator 04 - Type of Bill):

- 0111 (Hospital, Inpatient, Admit through Discharge Claim)
- 0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim)
- 0114 (Hospital, Inpatient, Last Claim)
- 0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim)
- 0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim)
- 0214 (Skilled Nursing-Inpatient, Interim, Last Claim)
- 0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim)
- 0224 (Skilled Nursing- Interim, Last Claim)
- 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim)
- 0284 (Skilled Nursing-Swing Beds, Interim, Last Claim)

AND

Discharge Status (Form Locator 17)

- 01 (Discharged to home care or self care (routine discharge))
- 02 (Discharged/transferred to a short term general hospital for inpatient care)
- 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)
- 04 (Discharged/transferred to an intermediate care facility)
- 05 Discharged/transferred to a designated cancer center or children's hospital
- 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care)
- 43 (Discharged/transferred to a federal health care facility)
- 50 (Hospice – home)
- 51 (Hospice - medical facility (certified) providing hospice level of care)
- 61 (Discharged/transferred to hospital-based Medicare approved swing bed)
- 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
- 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))

- 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
- 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
- 66 (Discharged/transferred to a Critical Access Hospital (CAH))
- 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)

OR

UB-04 (Form Locator 04 - Type of Bill):

- 0131 (Hospital Outpatient, Admit through Discharge Claim)
- 0134 (Hospital Outpatient, Interim, Last Claim)

AND

UB-04 (Form Locator 42 - Revenue Code):

- 0762 (Hospital Observation)
- 0490 (Ambulatory Surgery)
- 0499 (Other Ambulatory Surgery)

AND

Discharge Status (Form Locator 17)

- 01 (Discharged to home care or self care (routine discharge))
- 02 (Discharged/transferred to a short term general hospital for inpatient care)
- 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)
- 04 (Discharged/transferred to an intermediate care facility)
- 05 Discharged/transferred to a designated cancer center or children's hospital
- 06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care)
- 43 (Discharged/transferred to a federal health care facility)
- 50 (Hospice – home)
- 51 (Hospice - medical facility (certified) providing hospice level of care)
- 61 (Discharged/transferred to hospital-based Medicare approved swing bed)
- 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
- 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))
- 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
- 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
- 66 (Discharged/transferred to a Critical Access Hospital (CAH))
- 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)

Exclusions

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Patients that are discharged or expire before a gold standard medication list can be obtained.

0097 Medication Reconciliation

N/A

0554 Medication Reconciliation Post-Discharge (MRP)

N/A

0553 Care for Older Adults (COA) – Medication Review

N/A

0419 Documentation of Current Medications in the Medical Record

ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.

A patient is not eligible or excluded (B) from the performance denominator (PD) if one or more of the following reason exists:

- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Patients who died

Patients who left against medical advice (AMA) or discontinued care

Exclusion Details

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Please see exclusion listed above in S.10.

0097 Medication Reconciliation

N/A

0554 Medication Reconciliation Post-Discharge (MRP)

N/A

0553 Care for Older Adults (COA) – Medication Review

N/A

0419 Documentation of Current Medications in the Medical Record

For the purposes of identifying performance exclusions, Denominator Exclusions (B) are defined by providers reporting the exclusion clinical quality action. For this measure, the clinical exclusion code is numerator HCPCS G8430.

Current Medications not Documented, Patient not Eligible

G8430: Eligible professional attests the patient is not eligible for medication documentation

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

The PCPI methodology uses three categories of reasons for which a patient may be excluded 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. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. 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 example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception.

Comparison of NQF #0495, #0496 and #0497

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

0497 Admit Decision Time to ED Departure Time for Admitted Patients

Steward

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

Centers for Medicare & Medicaid

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Centers for Medicare & Medicaid

0497 Admit Decision Time to ED Departure Time for Admitted Patients

Centers for Medicare & Medicaid

Description

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department

0497 Admit Decision Time to ED Departure Time for Admitted Patients

Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status

Type

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

Outcome

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Process

0497 Admit Decision Time to ED Departure Time for Admitted Patients

Process

Data Source

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records

0497 Admit Decision Time to ED Departure Time for Admitted Patients

Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records

Level

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

Facility

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Facility

0497 Admit Decision Time to ED Departure Time for Admitted Patients

Facility

Setting

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

Hospital/Acute Care Facility

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Hospital/Acute Care Facility

0497 Admit Decision Time to ED Departure Time for Admitted Patients

Hospital/Acute Care Facility

Numerator Statement

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

0497 Admit Decision Time to ED Departure Time for Admitted Patients

Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.

Included Populations:

Any ED Patient from the facility's emergency department

Numerator Details

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

0497 Admit Decision Time to ED Departure Time for Admitted Patients

Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.

Included Populations:

Any ED Patient from the facility's emergency department

Excluded Populations:

Patients who are not an ED Patient

Data Elements:

- Decision to Admit Date
- Decision to Admit Time
- ED Departure Date
- ED Departure Time
- ED Patient
- ICD-9-CM Principal Diagnosis Code

Denominator Statement

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

0497 Admit Decision Time to ED Departure Time for Admitted Patients

Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.

Included Populations:

Any ED Patient from the facility's emergency department

Excluded Populations:

Patients who are not an ED Patient

Data Elements:

- Decision to Admit Date

- Decision to Admit Time
- ED Departure Date
- ED Departure Time
- ED Patient
- ICD-9-CM Principal Diagnosis Code

Denominator Details

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

Any ED Patient from the facility's emergency department.

Data Element Name: ED Patient

Collected For: ED-1, ED-2

Definition: Patient received care in a dedicated emergency department of the facility.

Suggested Data Collection Question: Was the patient an ED patient at the facility?

Allowable Values:

Y (Yes) There is documentation the patient was an ED patient.

N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.

Notes for Abstraction:

- For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department.
- Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).
- Patients presenting to the ED who do not receive care or services in the ED abstract as a "No" (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).
- Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a "Yes".

ED:

- If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select "No". This applies even if the emergency department or observation unit is part of your hospital's system (e.g., your hospital's free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select "No", even if the transferred patient is seen in this facility's ED.
- If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select "No". This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select "No", even if the transferred patient is seen in this facility's ED.

Suggested Data Sources:

- Emergency department record

- Face sheet
- Registration form

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

- Urgent Care
- Fast Track ED
- Terms synonymous with Urgent Care

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Any ED Patient from the facility's emergency department

E/M Codes Emergency Department

- 99281 Emergency department visit, new or established patient
- 99282 Emergency department visit, new or established patient
- 99283 Emergency department visit, new or established patient
- 99284 Emergency department visit, new or established patient
- 99285 Emergency department visit, new or established patient
- 99291 Critical care, evaluation and management

0497 Admit Decision Time to ED Departure Time for Admitted Patients

Any ED Patient from the facility's emergency department.

Data Element Name: ED Patient

Collected For: ED-1, ED-2

Definition: Patient received care in a dedicated emergency department of the facility.

Suggested Data Collection Question: Was the patient an ED patient at the facility?

Allowable Values:

Y (Yes) There is documentation the patient was an ED patient.

N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.

Notes for Abstraction:

- For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department.
- Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).
- Patients presenting to the ED who do not receive care or services in the ED abstract as a "No" (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).
- Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a "Yes".

ED:

- If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select “No”. This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select “No”, even if the transferred patient is seen in this facility’s ED.
- If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select “No”. This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select “No”, even if the transferred patient is seen in this facility’s ED.

Suggested Data Sources:

- Emergency department record
- Face sheet
- Registration form

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

- Urgent Care
- Fast Track ED
- Terms synonymous with Urgent Care

Exclusions

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

Patients who are not an ED Patient

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Patients who expired in the emergency department

0497 Admit Decision Time to ED Departure Time for Admitted Patients

Patients who are not an ED Patient

Exclusion Details

0495 Median Time from ED Arrival to ED Departure for Admitted ED Patients

All non-ED patients are excluded from this measure.

Data Element Name: ED Patient

Collected For: ED-1, ED-2

Definition: Patient received care in a dedicated emergency department of the facility.

Suggested Data Collection Question: Was the patient an ED patient at the facility?

Allowable Values:

Y (Yes) There is documentation the patient was an ED patient.

N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.

Notes for Abstraction:

- For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department.
- Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).
- Patients presenting to the ED who do not receive care or services in the ED abstract as a “No” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).
- Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a “Yes”.

ED:

- If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select “No”. This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select “No”, even if the transferred patient is seen in this facility’s ED.
- If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select “No”. This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select “No”, even if the transferred patient is seen in this facility’s ED.

Suggested Data Sources:

- Emergency department record
- Face sheet
- Registration form

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

- Urgent Care
- Fast Track ED
- Terms synonymous with Urgent Care

0496 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Discharge Code Value 6: Expired

0497 Admit Decision Time to ED Departure Time for Admitted Patients

All non-ED patients are excluded from this measure, with no other exclusions.

Data Element Name: ED Patient

Collected For: ED-1, ED-2

Definition: Patient received care in a dedicated emergency department of the facility.

Suggested Data Collection Question: Was the patient an ED patient at the facility?

Allowable Values:

Y (Yes) There is documentation the patient was an ED patient.

N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.

Notes for Abstraction:

- For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department.
- Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).
- Patients presenting to the ED who do not receive care or services in the ED abstract as a “No” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).
- Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a “Yes”.

ED:

- If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select “No”. This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select “No”, even if the transferred patient is seen in this facility’s ED.
- If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select “No”. This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select “No”, even if the transferred patient is seen in this facility’s ED.

Suggested Data Sources:

- Emergency department record
- Face sheet
- Registration form

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

- Urgent Care
- Fast Track ED
- Terms synonymous with Urgent Care

Appendix G: University of Minnesota Memorandum

MEMORANDUM

August 5, 2014

To: National Quality Forum Consensus Standard Approval Committee

From: Ira Moscovice PhD, Jill Klingner RN PhD

Rural Health Research Center

University of Minnesota

Re: Emergency Transfer Communication Measures NQF 0291-0297 Modification plans.

We value the efforts of the National Quality Forum's work to facilitate healthcare improvement. We appreciate your input on the Emergency Transfer Communication Measures. The measures were developed to fill a gap of measurement in emergency medicine communication.

We will modify NQF measure 0291 to include all of the data elements previously detailed in measures 0291-0297. The measures 0291-0297 addressed care issues in the same population and the same setting. The measures addressed patients' with any condition who all experienced a transfer from an Emergency Department to any other healthcare facility.

For the single measure, identification of the sample, data collection and specifications for elements will remain the same. Scoring of the subsections will remain all-or-none. The single measure score will be a sum of the scores from the seven subsection scores. Specifically the measure calculation is as follows:

Each of the seven SUB SECTIONS ARE calculated using an all-or-none approach. Data elements are identified for each SUBSECTION. If the data element is not appropriate for the patient, elements are scored as NA (not applicable) and are counted in the measure as a positive, or 'yes,' response and the patient will meet that element criteria. The patient will either need to meet the criteria for all of the data elements (or have an NA) to pass the SUBSECTION. The subsections are used to identify areas with opportunity for improvement. The all or none calculation approach for the subsections is in current use in two studies in nine states including almost 200 hospitals. This approach is under consideration for the Phase 3 of MBQIP. Maintaining the subsection scoring facilitates an EASY transition to the one measure approach and simplifies the transition to a reporting and payment measure.

The reporting measure is a sum of the subsection scores divided by the number of patients. The facility score is the average of the patients scores (range of 0-7) for each facility. This single score will provide an overview of the facility's communication performance for patients that are transferred from their Emergency Department to another healthcare facility.

In discussing this approach with NQF staff, it was determined that this approach addresses the concerns of the Committee and that constructing the measure as a composite—which was discussed as a possibility at the July CSAC meeting—is not necessary. In addition, additional testing would not be necessary.

This measure will be useful for public reporting, Pay-for-Performance, quality assessment and quality improvement.

Detailed information is attached. Emergency Department Transfer Communication Measure Specifications

ED Transfer Communication QUALITY MEASURE Set

Measure ID # ²	Measure Short Name	NQF ¹ Measure Number
EDTC-SUB 1	Administrative communication	0291
EDTC-SUB 2	Patient information	0291
EDTC-SUB 3	Vital signs	0291
EDTC-SUB 4	Medication information	0291
EDTC-SUB 5	Physician or practitioner generated information	0291
EDTC-SUB 6	Nurse generated information	0291
EDTC-SUB 7	Procedures and tests	0291

1. NQF National Quality Forum <http://www.qualityforum.org/gps>
2. NQMC National Quality Measure Clearinghouse <http://www.qualitymeasures.ahrq.gov/>

Background of the Measures

In 2003, an expert panel convened by the University of Minnesota Rural Health Research Center and Stratis Health identified ED care as an important quality assessment measurement category for rural hospitals. While emergency care is important in all hospitals, it is particularly critical in rural hospitals where the size of the hospital and geographic realities make organizing triage, stabilization, and transfer of patients more important. Communication between providers promotes continuity of care and may lead to improved patient outcomes. These measures were piloted by rural hospitals in Minnesota, Utah, Nevada, Washington, Ohio, Pennsylvania, New York and Hawaii; projects took place from October 2005 through July 2014. Results of the pilot projects indicated room for improvement in ED care and transfer communication.

Aggregate project results are available at

http://flexmonitoring.org/documents/DataSummaryReportNo8_Rural-Hospital-ED-Quality-Measures.pdf and <http://flexmonitoring.org/documents/FlexDataSummaryReport3.pdf>.

Rationale

Communication problems are a major contributing factor to adverse events in hospitals, accounting for 65% of sentinel events tracked by The Joint Commission. In addition, research indicates that deficits exist in the transfer of patient information between hospitals and primary care physicians in the community, and between hospitals and long-term facilities. Transferred patients are excluded from the calculation of most national

quality measures, such as those used in Hospital Compare. The Hospital Compare Web site was created to display rates of Process of Care measures using data that are voluntarily submitted by hospitals.

The Joint Commission has adopted National Patient Safety Goal 2, "Improve the Effectiveness of Communication Among Caregivers." This goal required all accredited hospitals to implement a standardized approach to hand-off communications, including nursing and physician handoffs from the emergency department (ED) to inpatient units, other hospitals, and other types of health care facilities. The process must include a method of communicating up-to-date information regarding the patient's care, treatment, and services; condition; and any recent or anticipated changes. (Note: The National Patient Safety Goals are reviewed and modified periodically. In 2013 a communication goal focuses on the communication of test results.) http://www.jointcommission.org/assets/1/6/2013_HAP_NPSG_final_10-23.pdf

Limited attention has been paid to the development and implementation of quality measures specifically focused on patient transfers between EDs and other facilities. These measures are important for all health care facilities, but especially so for small rural hospitals that transfer a higher proportion of ED patients to other hospitals than larger urban facilities.

While many aspects of hospital quality are similar for urban and rural hospitals (e.g., providing heart attack patients with aspirin), the urban/rural contextual differences result in differences in emphasis on quality measurement. Because of its role in linking residents to urban referral centers, important aspects of rural hospital quality include triage-and-transfer decision making about when to provide a particular type of care, transporting patients, and coordinating information flow to specialists beyond the community.

Emergency care is important in all hospitals, but it is particularly important in rural hospitals. Because of their size, rural hospitals are less likely to be able to provide more specialized services, such as cardiac catheterization or trauma surgery. Rural residents often need to travel greater distances than urban residents to get to a hospital initially. In addition, their initial point of contact is less likely to have specialized services and staff found in tertiary care centers, so they are also more likely to be transferred. These size and geographic realities increase the importance of organizing triage, stabilization, and transfer in rural hospitals which, in turn, suggest that measurement of these processes is an important issue for rural hospitals.

The ED Transfer Communication measures aim to provide a means of assessing how well key patient information is communicated from an ED to any healthcare facility. They are applicable to patients with a wide range of medical conditions (e.g., acute myocardial infarction, heart failure, pneumonia, respiratory compromise and trauma) and are relevant for both internal quality improvement purposes and external reporting to consumers and purchasers. The results of the field tests suggest that significant opportunity exists for improvement on these measures.

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Population and Sampling

ED Transfer Communication (EDTC) Initial Patient Population

(Update discharge codes with CMS changes as appropriate.)

The population of the EDTC measure set is defined by identifying patients admitted to the emergency department and transfers from the emergency department to these facilities:

- 3 Hospice –healthcare facility
- 4a Acute Care Facility- General Inpatient Care
- 4b Acute Care Facility- Critical Access Hospital
- 4c Acute Care Facility- Cancer Hospital or Children’s Hospital
- 4d Acute Care Facility – Department of Defense or Veteran’s Administration
- 5 Other health care facility (i.e. nursing homes, skilled nursing facilities, rehabilitation centers, swing beds; facilities with 24 hour nursing supervision.)

Note: ED patients that have been put in observation status and then are transferred to another hospital or health care facility should be included.

Exclusions:

- 1 Home
- 2 Hospice-home
- 6 Expired
- 7 AMA (left against medical advice)
- 8 Not documented/unable to determine

Sample Size Requirements

Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. A hospital may choose to use a larger sample size than is required. Hospitals whose initial patient population size is less than the minimum number of cases per quarter for the measure set cannot sample.

Regardless of the option used, hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. Due to exclusions, hospitals selecting sample cases **MUST** submit **AT LEAST** the minimum required sample size.

The following sample size tables for each option automatically build in the number of cases needed to obtain the required sample sizes. For information concerning how to perform sampling, refer to the Population and Sampling Specifications section in this manual.

Quarterly Sampling

Hospitals performing quarterly sampling for ED Transfer Communication must ensure that its initial

patient population and sample size meet the following conditions:

Quarterly Sample Size

Based on Initial Patient Population Size for the EDTC Measure Set

Hospital's Measure

Average Quarterly Initial Patient Population Size "N"	Minimum Required Sample Size "n"
<u>≥ 45</u>	45
1 - 44	No sampling; 100% Initial Patient Population required

Monthly Sampling

Hospitals performing monthly sampling for EDTC must ensure that its Initial Patient Population and sample size meet the following conditions:

Monthly Sample Size

Based on Initial Patient Population Size for the EDTC Measure Set

<i>Hospital's Measure</i> Average Monthly Initial Patient Population Size "N"	Minimum Required Sample Size "n"
<u>≥15</u>	15
< 15	No sampling; 100% Initial Patient Population required

Measure Calculation

Each of the seven SUB SECTIONS ARE calculated using an all-or-none approach. Data elements are identified for each SUBSECTION. If the data element is not appropriate for the patient, elements are scored as NA (not applicable) and are counted in the measure as a positive, or 'yes,' response and the patient will meet that element criteria. The patient will either need to meet the criteria for all of the data elements (or have an NA) to pass the SUBSECTION. The subsections are used to identify areas with opportunity for improvement. The all or none calculation approach for the subsections is in current use in two studies in nine states including almost 200 hospitals. This approach is under consideration for the Phase 3 of MBQIP. Maintaining the subsection scoring facilitates an EASY transition to the one measure approach and simplifies the transition to a reporting and payment measure.

The reporting measure is a sum of the subsection scores divided by the number of patients. The facility score is the average of the patients scores (range of 0-7) for each facility. This single score will provide an overview of the facility's communication performance for patients that are transferred from their Emergency Department to another healthcare facility.

Considerations for Electronic Transfer of Information

For health systems with shared electronic medical records, documentation must indicate that data elements had been entered into the data system and were available to the receiving facility prior to transfer for Administrative Measures or within 60 minutes of discharge for all other measures. If there are not shared records, “sent” means that medical record documentation indicates the information went with the patient via fax, phone, or internet/Electronic Health Record.

Measure EDTC-SUB 1

Measure Information Form

Measure Set: ED Transfer Communication (EDTC)

Set Measure ID#: EDTC-SUB 1

Performance Measure Name: Administrative communication

Description: Patients who are transferred from an ED to another healthcare have physician to physician communication and nurse to nurse communication prior to discharge.

Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant tests.

Type of Measure: Process

Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility prior to transfer.

- Nurse to nurse communication
- Physician to physician communication

Denominator Statement: All transfers from ED to another healthcare facility

Included Populations: ED Transfers to another healthcare facility

Excluded Populations: None

Calculation

Rate =
$$\frac{\text{\# of patients who have a yes or NA for both measures: nurse to nurse communication and physician to physician communication}}{\text{All transfers from ED to another health care facility}}$$

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Measure Analysis Suggestions: The data elements for each of the two communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and

Sampling Specifications Section.

Measure EDTC-SUB 2

Measure Information Form

Measure Set: ED Transfer Communication (EDTC)

Set Measure ID#: EDTC-SUB 2

Performance Measure Name: Patient Information

Description: Patient who are transferred from an ED to another healthcare facility have patient identification information sent to the receiving facility within 60 minutes of discharge

Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant tests.

Type of Measure: Process

Improvement Noted As: An increase in the rate

Numerator Statement:

Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of departure.

- Name
- Address
- Age
- Gender
- Significant others contact information
- Insurance

Denominator Statement: ED transfers to another healthcare facility

Included Populations: All transfers from ED to another healthcare facility

Excluded Populations: None

Calculation

Rate =
$$\frac{\text{\# of patients who have a yes or NA for all measures: name, address, age, gender, contact, insurance}}{\text{All transfers from ED to another healthcare facility}}$$

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Measure Analysis Suggestions: The data elements for each of the six communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specification Section.

Measure EDTC-SUB 3

Measure Information Form

Measure Set: ED Transfer Communication (EDTC)

Set Measure ID#: EDTC-SUB 3

Performance Measure Name: Vital Signs

Description: Patients who are transferred from an ED to another healthcare facility have communication with the receiving facility within 60 minutes of discharge for patient's vital signs

Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant tests.

Type of Measure: Process

Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred to another health care facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of discharge.

- Pulse
- Respiratory rate
- Blood pressure
- Oxygen saturation
- Temperature
- Glasgow score or other neuro assessment for trauma, cognitively altered or neuro patients only

Denominator Statement: ED transfers to another healthcare facility

Included Populations: All transfers from ED to another healthcare facility

Excluded Populations: None

Calculation

Rate = # of patients who has a yes or NA for all measures: pulse, respiration, blood pressure, oxygen saturation, temperature and neuro assessment
All transfers from ED to another healthcare facility

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Measure Analysis Suggestions: The data elements for each of the six communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.

Measure EDTC-SUB 4

Measure Information Form

Measure Set: ED Transfer Communication (EDTC)

Set Measure ID#: EDTC-SUB 4

Performance Measure Name: Medication Information

Description: Patients who are transferred from an ED to another healthcare facility have communication with the receiving facility within 60 minutes of discharge for medication information.

Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant tests.

Type of Measure: Process

Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred from an ED to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of departure.

- Medications administered in ED
- Allergies
- Home medications

Denominator Statement: ED transfers to another healthcare facility

Included Populations: All transfers from ED to another healthcare facility

Excluded Populations: None

Calculation

of patients who have a yes or NA for all measures: Medications administered in ED,

Rate =
$$\frac{\text{\# of patients who have a yes or NA for all measures: Medications administered in ED, allergies and home medications}}{\text{All transfers from ED to another healthcare facility}}$$

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Measure Analysis Suggestions: The data elements for each of the three communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.

Measure EDTC-SUB 5

Measure Information Form

Measure Set: ED Transfer Communication (EDTC)

Set Measure ID#: EDTC-SUB 5

Performance Measure Name: Physician or Practitioner generated information

Description: Patients who are transferred from an ED to another healthcare facility have communication with the receiving facility within 60 minutes of discharge for history and physical and physician orders and plan

Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant tests.

Type of Measure: Process

Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of discharge.

- History and physical
- Reason for transfer and/or plan of care

Denominator Statement: ED transfers to another healthcare facility

Included Populations: All transfers from ED to another healthcare facility

Excluded Populations: None

Calculation:

Rate =
$$\frac{\text{\# of patients who have a yes for all measures: history and physical and reason for transfer and/or plan of care}}{\text{All transfers from ED to another healthcare facility}}$$

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Measure Analysis Suggestions: The data elements for each of the two communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.

Measure EDTC-SUB 6

Measure Information Form

Measure Set: ED Transfer Communication (EDTC)

Set Measure ID#: EDTC-SUB 6

Performance Measure Name: Nurse Generated Information

Description: Patients who are transferred from an ED to another healthcare facility have communication with the receiving facility within 60 minutes of discharge for key nurse documentation elements

Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant

tests.

Type of Measure: Process

Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of departure.

- Assessments/interventions/response
- Sensory Status (formerly Impairments)
- Catheters
- Immobilizations
- Respiratory support
- Oral limitations

Denominator Statement: Transfers from an ED to another healthcare facility

Included Populations: All transfers from an ED to another healthcare facility

Excluded Populations: None

Calculation:

$$\text{Rate} = \frac{\text{\# of patients who have a yes or NA for all measures: assessments/interventions/response, sensory status, catheter, immobilization, respiratory support, oral limitations}}{\text{All transfers from ED to another healthcare facility}}$$

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Measure Analysis Suggestions: The data elements for each of the six communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.

Measure EDTC-SUB 7

Measure Information Form

Measure Set: ED Transfer Communication (EDTC)

Set Measure ID#: EDTC-SUB 7

Performance Measure Name: Procedures and Tests

Description: Patients who are transferred from an ED to another healthcare facility have communication with the receiving facility within 60 minutes of discharge of tests done and results sent.

Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving facility

provides continuity of care and avoids medical errors and redundant tests.

Type of Measure: Process

Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of discharge.

- Tests and procedures done
- Tests and procedure results sent

Denominator Statement: Transfers from an ED to another healthcare facility

Included Population: All transfers from an ED to another healthcare facility

Excluded Populations: None

Calculation:

Rate =
$$\frac{\text{\# of patients who have a yes or NA for all measures: test and procedures done and test and procedure results sent}}{\text{All transfers from ED to another healthcare facility}}$$

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Measure Analysis Suggestions: The data elements for each of the two communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.

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